

# **CyberMed Electronic Health Record (EHR)**



**Version 1.00  
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Office of Information Technology (OIT)  
Joseph P. Addabbo Family Health Center

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## DOCUMENT REVISION HISTORY

Date of Change	Location of Revision	Revision
August 2012	Many sections	The information was updated to reflect Version 4.0

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## 1.0 Introduction:

CyberMed (EHR) application is based on a component framework. This means that the application the user sees is actually composed of functional components most suited to the user's role in patient care. Thus, the application used by a front desk clerk will look much different from that used by a physician. This User Manual is organized into chapters, where each chapter is devoted to a particular functional component. Depending on a user's role, some chapters will be valid while others will not.

## 2.0 Accessing the EHR:

This section provides information about how to access the Electronic Health Record (EHR) application. Double-click the EHR application icon on your desktop or open Internet Explorer

 in the start menu  and type "<https://appserver.addabbo.org/>" in the Internet Explorer and click "Go" or enter key.

Once you clicked on the "Enter Key", a page may be displayed as shown below:

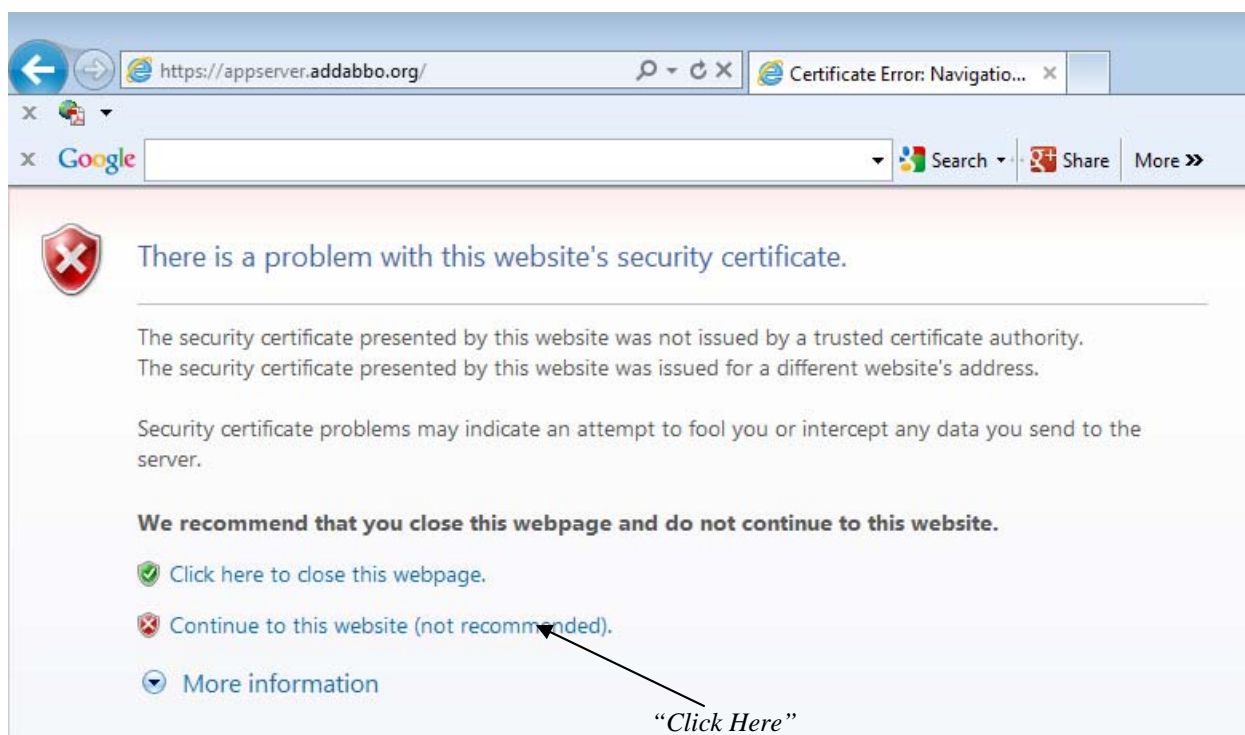


Figure 1.1

Click on "Continue to this website (not recommended)".

Next, the logon screen displays asking you to enter your Username ID and Password.

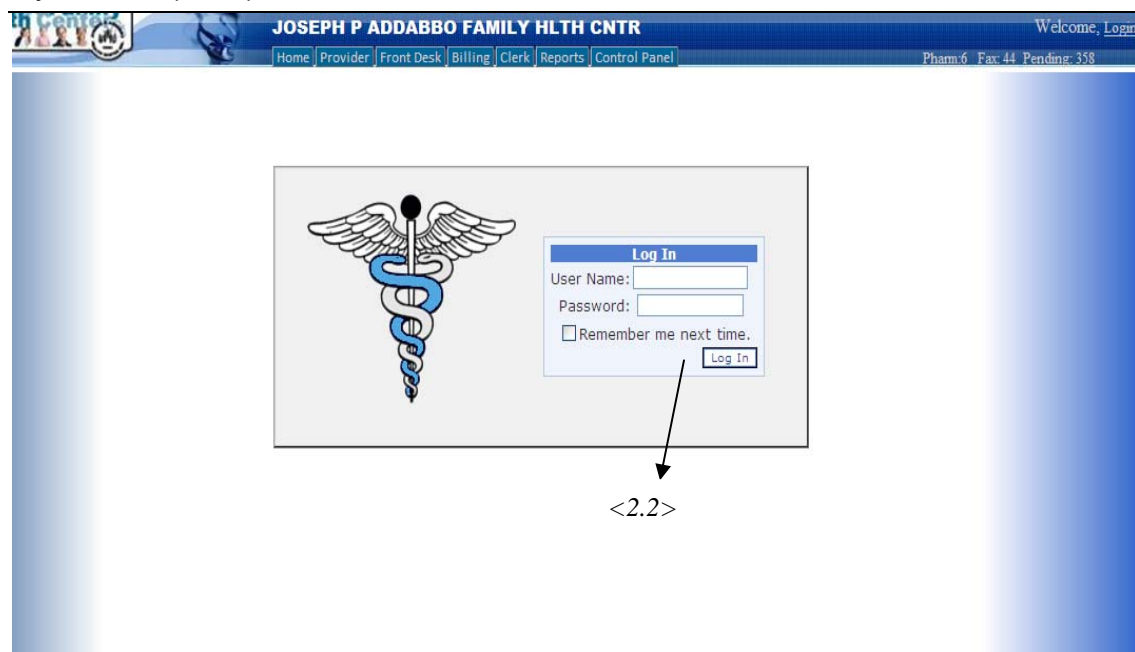


Figure 2.1: Logon Window to the EHR system

Type your “User Name” and “Password” and press either the enter key or click on “Log in” (<2.2>)

The IT Department assigns your Username ID and Password. Please request your paper work from your supervisor and submit it at the HR office at Site 1, 3<sup>rd</sup> floor to request access.

Once you type in the assigned Username ID and Password, Click on the “Login” button to enter into the system. You are now directed to the welcome page as shown below: (<3.1>)



Figure 3.1

### 3.0 Features of Available Tabs:

The following tool bar appears in every page within the CyberMed EHR. This tool bar provides the needed information for you to know when you are using the software.



Figure 3.2

## 4.0 Provider Guide

Once you click on the “*Provider*” tab at the top of the page, a page as displayed below will appear. You can either click on the drop down list and select a provider, or enter the provider’s number and the name of the provider will appear (<4.2>). Select the date and then click on “*Go*” (<4.3>). The appointment list for that provider will appear with the list of the patients that have appointments with that provider for the day.

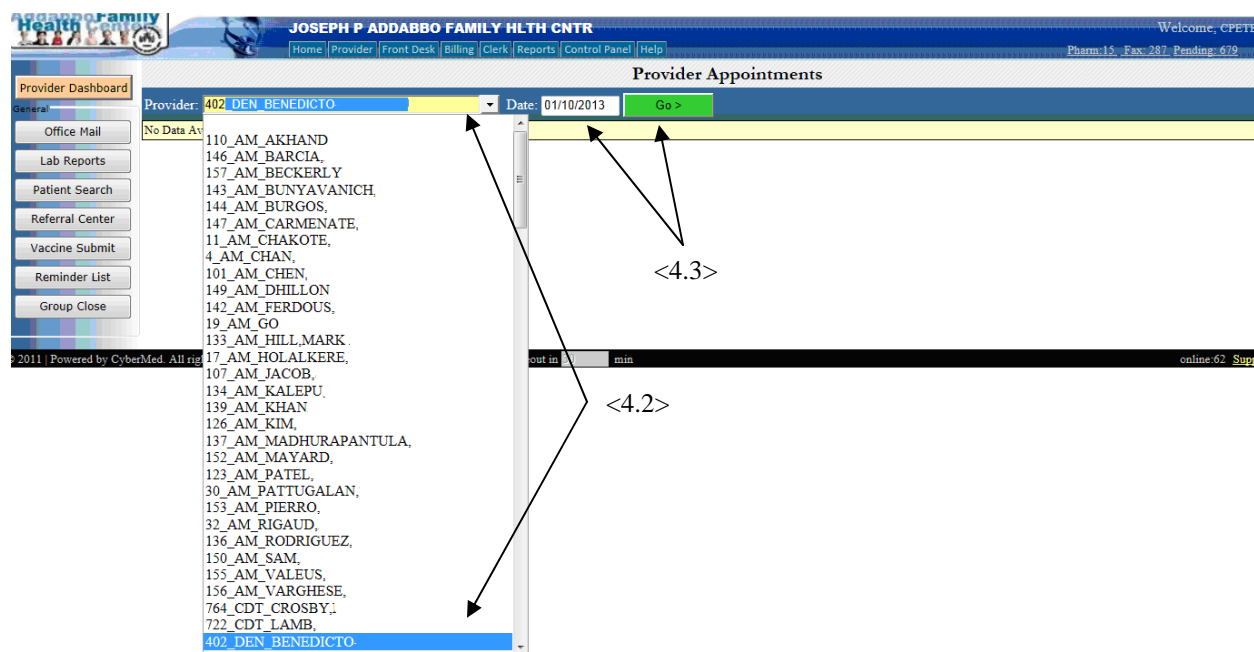


Figure 4.1



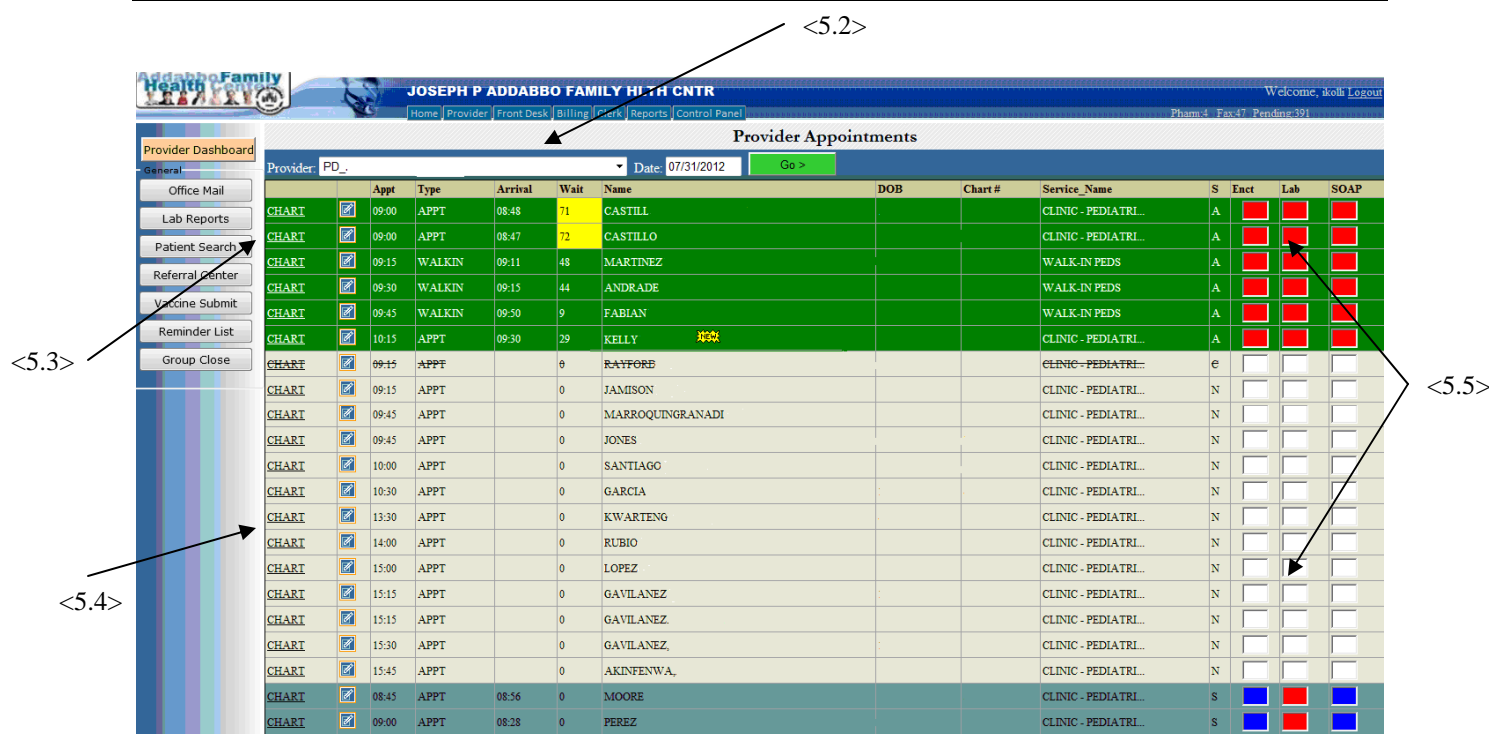


Figure 5.1

In the provider's name, the provider's department appears first followed by the provider's name, followed by the 3-digit provider number (e.g. PD\_<name>\_000) as shown in figure (<5.2>)

The displayed appointments are the patients who are scheduled for the day.

In the patients appointment list the green colored appointments are the patients who have already registered and are in the building waiting for the provider (<5.3>)

The grey colored lists are the patients who have already seen the provider and finished their encounters. (<5.4>)

We can also view the patient's wait time. The normal green color shows patients who are waiting for less than 60 minutes. The yellow color shows that the patient has been waiting between 60 to 90 minutes. Red shows patients waiting over 90 minutes. This gives the provider an idea of how long the patients are waiting at a glance.

The "Enct, Lab, SOAP" are also color coded. The red color means the notes are not done/ordered (in case of lab). Blue means the following module has been completed. Once you get the list of patients, select the patient whose information you want to review/change (<5.5>). Click on "Chart" to get the patient's chart information (<5.3>).

## 4.1 Patient Chart:

The image below displays the different tabs that are available for the provider in order for them to view the patient's chart information when clicked on "Chart" in the appointment page. *Figure 6.1.*

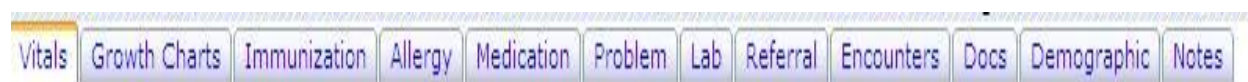


Figure 6.1

### 4.1.1 Vitals Summary:

This displays a list of vitals taken in all the previous visits. Click on vital trend to view the height, weight, temp, BP, Pulse, and BMI trend. (*Figure 6.3*)

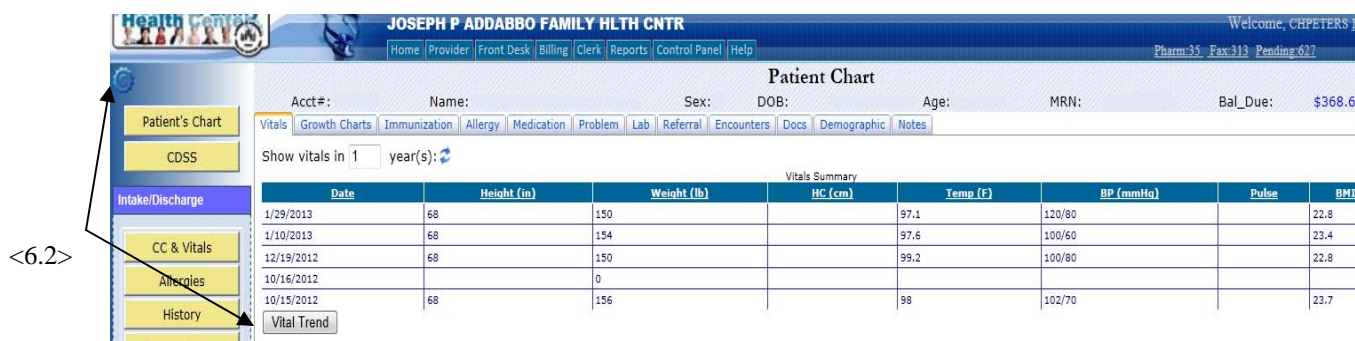


Figure 6.1

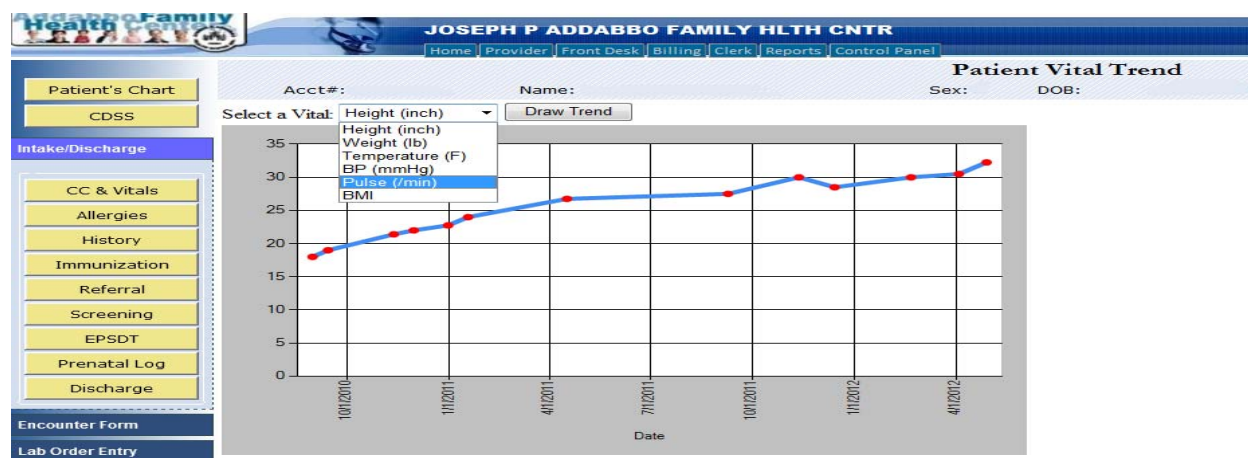


Figure 6.3

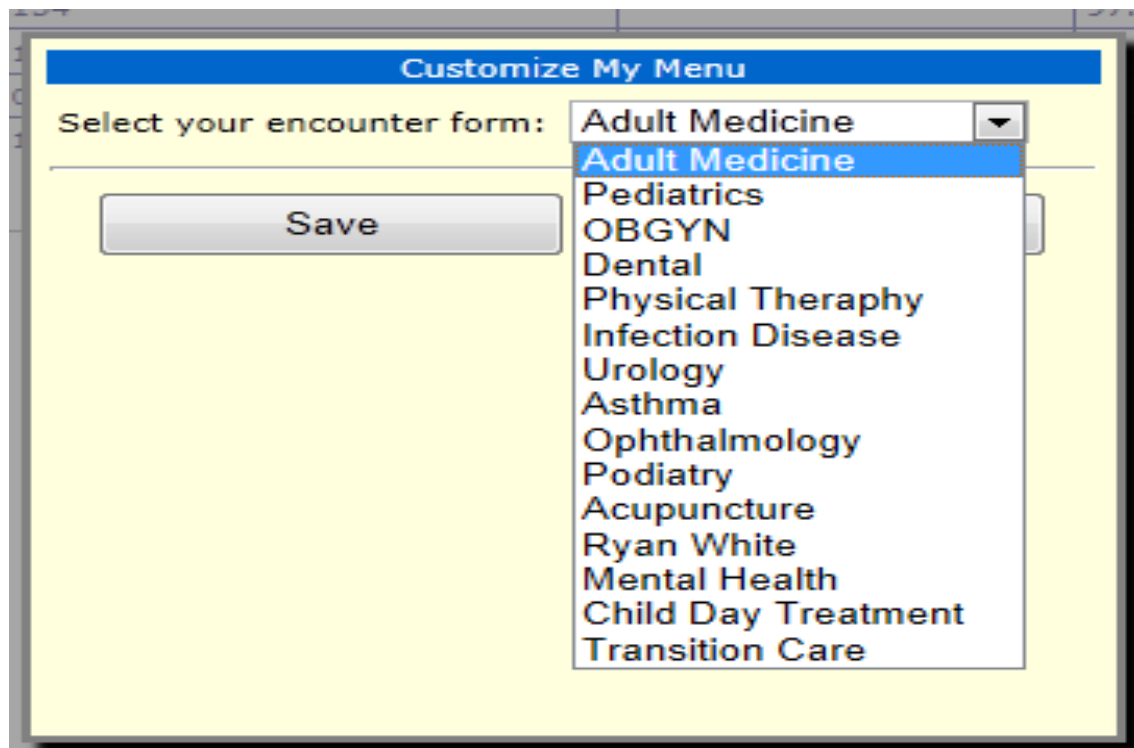



Figure 6.4

To customize your own encounter form menu, click on the  icon (<6.2>). The above page will be displayed. Select the department associated with you and then click on the “Save” button. By doing so, the department that the user selected will be displayed when clicked on the “Encounter” tab on the left side of the page, eliminating the other departments encounter forms.

### 4.1.2 Growth Chart:

In the cases where the patient is below 18 years old, we can select the patient's weight, length, stature, H.C. or BMI charts by clicking each button. (<6.4>).

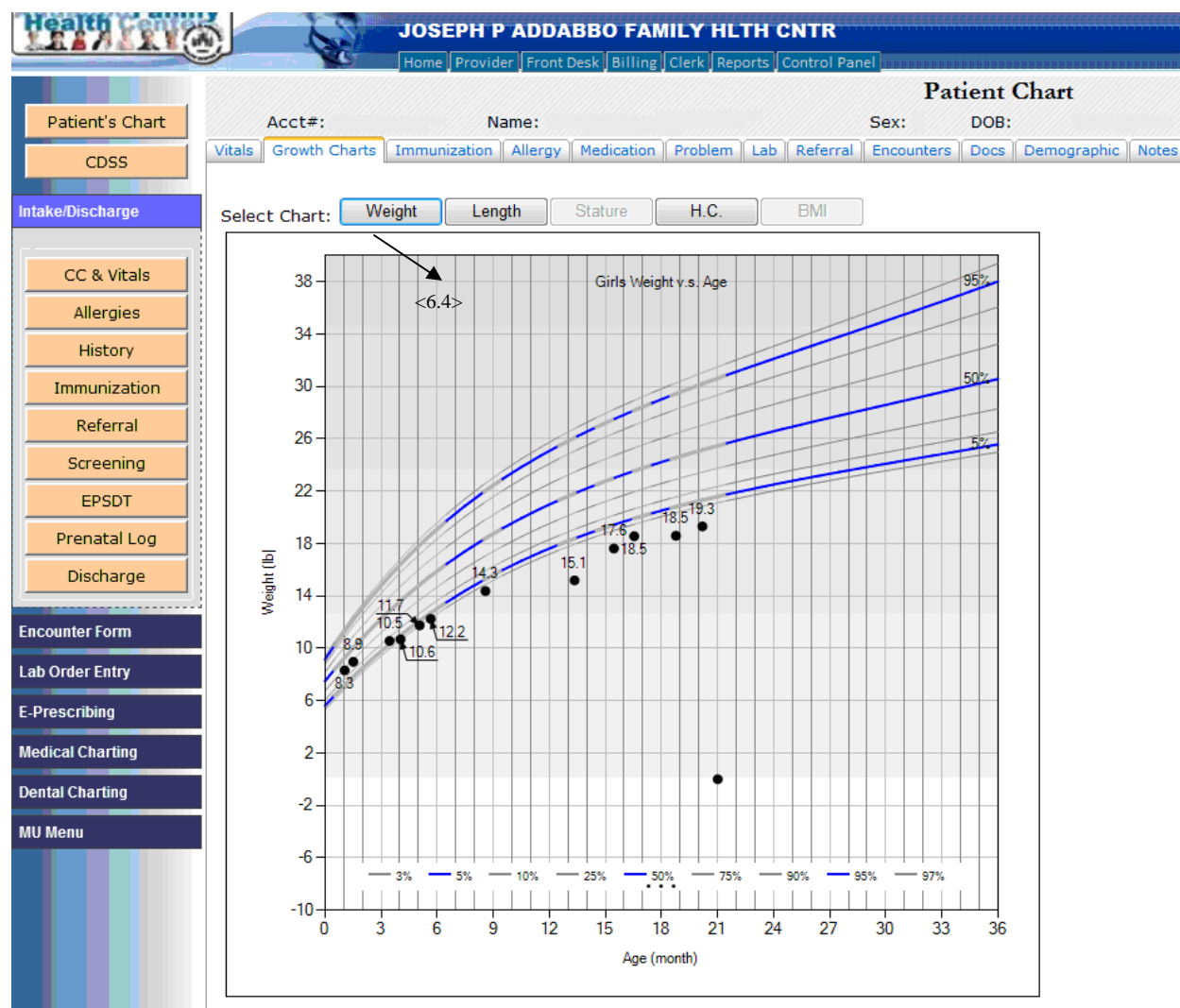


Figure 6.5

## 4.2 Immunization:

This tab displays the patient's immunization information. In case the patient's CIR ID is present, please enter in the text box below and click on “*Retrieve from CIR*” to get the patients updated immunization information.

In order to add new immunization information, click on the “*Add New*” button (<6.7>).

**Patient Chart**

Acct#: \_\_\_\_\_ Name: \_\_\_\_\_ Sex: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ MRN: \_\_\_\_\_ Bal\_Due: \$187.47

Vitals Growth Charts **Immunization** Allergy Medication Problem Lab Referral Encounters Docs Demographic Notes

PEDS **ADULT**

The record was last updated on 2/20/2012 10:35:16 AM.

Enter patient's CIR ID: \_\_\_\_\_ [Retrieve from CIR](#) [Add New](#)

Vaccine	D1	D2	D3	D4	D5	Next Due
DTP	DTaP-IPV/Hib (Pentacel) 9/13/2010	DTaP-IPV/Hib (Pentacel) 11/11/2010	DTaP-IPV/Hib (Pentacel) 1/17/2011	DTaP 11/14/2011		07/29/2014 DTaP
H1N1 Influenza						No longer recommended
HepA	Hep A, ped/adol, 2 dose 8/4/2011	Hep A, ped/adol, 2 dose 2/20/2012				Completed Vaccine Series
HepB	Hep B, adolescent or pediatric 7/28/2010	Hep B, adolescent or pediatric 9/13/2010	Hep B, adolescent or pediatric 1/17/2011			Completed Vaccine Series
Hib	DTaP-IPV/Hib (Pentacel) 9/13/2010	DTaP-IPV/Hib (Pentacel) 11/11/2010	DTaP-IPV/Hib (Pentacel) 1/17/2011	Hib (PRP-T) 11/14/2011		Completed Vaccine Series
Human Papillomavirus						07/29/2021 HPV
Influenza						09/01/2011 influenza, NOS
Meningococcal						07/29/2021 meningococcal (MCV4) Recommended for high risk groups
MMR	MMR 8/4/2011					07/29/2014 MMR
Pneumo, Conjugate	Pneumococcal, PCV-13 9/13/2010	Pneumococcal, PCV-13 11/11/2010	Pneumococcal, PCV-13 1/17/2011	Pneumococcal, PCV-13 11/14/2011		Completed Vaccine Series
Polio	DTaP-IPV/Hib (Pentacel) 9/13/2010	DTaP-IPV/Hib (Pentacel) 11/11/2010	DTaP-IPV/Hib (Pentacel) 1/17/2011			07/29/2014 IPV

Figure 6.8

**Immunizations**

Acct#:      Name:      Sex:      DOB:

Select Vaccines

Group	Vaccine Name
HepB	Choose Vaccine....
DTP	Choose Vaccine....
Hib	DTaP-Hib-IPV
Polio	Choose Vaccine....
Pneumo. Conjugate	Choose Vaccine....
Rotavirus	Choose Vaccine....
MMR	Choose Vaccine....
Varicella	MMRV
HepA	Choose Vaccine....
Meningococcal	Choose Vaccine....
Human Papillomavirus	Choose Vaccine....
Influenza	Influenza, seasonal, injectable, preservative free
H1N1 Influenza	Choose Vaccine....

Which default date do you want to use?

☒ Today

☐ Another Date ->

☐ None (enter individually)

Indicate Patient's VFC Eligibility:

Medicaid

< Back      Next >

Figure 6.9

Please select the vaccine to be given (<6.10>). The default date is today. In case the date given is not today then select the date and then indicate the patient's VFC eligibility. (<6.11>)

Select the lot number from the drop-down list, Admin Site, Route, and Reaction. In case the lot number is not available in the list, please add the new lot by clicking the “*New Lot*” button (<6.13>).

In the next page (Figure 6.14), enter the lot information, Manufacturer, Source, etc., and save it to select again from the list in the previous page (<6.16>). In case the vaccine given elsewhere needs to be recorded into the system, please select “*Historic Record*” to enter into the system. (<6.14>)

**JOSEPH P ADDABBO FAMILY HLTH CNTR**

Home | Provider | Front Desk | Billing | Clerk | Reports | Control Panel

**Immunizations**

Acct#: \_\_\_\_\_ Name: \_\_\_\_\_ Sex: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ MRN: \_\_\_\_\_

#	Selected Vaccine Name	Given Here / Historic Record	Select Lot	Date Given	VIS	Admin Site	Route	Reaction
1	DTaP-Hib-IPV	<input type="radio"/> Given Here <input type="radio"/> Historic Record	C4116AA_PMC_Expired On 02/18/2013	07/31/2012	12/16/1998	Left Arm	IM	
2	MMRV	<input type="radio"/> Given Here <input checked="" type="radio"/> Historic Record	1004AA_MSD_Expired On 06/28/2013	07/31/2012	03/13/2008	Left Thigh	SC	
3	Influenza, seasonal, injectable, preservative free	<input type="radio"/> Given Here <input checked="" type="radio"/> Historic Record		07/31/2012	07/26/2011	Left Deltoid	IM	

< Back      Next >

Figure 6.12

**JOSEPH P ADDABBO FAMILY HLTH CNTR**

Home | Provider | Front Desk | Billing | Clerk | Reports | Control Panel

**Immunizations**

Acct#: \_\_\_\_\_ Name: \_\_\_\_\_ Sex: \_\_\_\_\_ DOB: \_\_\_\_\_

**Enter New Lot Information:**

Vaccine: DTaP-Hib-IPV

Lot Number: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Manufacturer: CSL\_CSL Behring, Inc

Source: Federally supported

< Back      Save

☐ Include expired Lots      Refresh

**Existing Lots**

CVX Code	Vaccine Name	Lot #	Expired On	Manufacturer	Source	Delete
120	DTaP-Hib-IPV	C4193AA	9/17/2013	sanofi pasteur	Supported by Private Insurance or Other Private Funds	Delete
120	DTaP-Hib-IPV	C4082AA	8/15/2013	sanofi pasteur	Supported by Private Insurance or Other Private Funds	Delete
120	DTaP-Hib-IPV	4158AA	8/7/2013	sanofi pasteur	Federally supported	Delete
120	DTaP-Hib-IPV	C4158AA	8/7/2013	sanofi pasteur	Federally supported	Delete
120	DTaP-Hib-IPV	C4157AA	8/7/2013	sanofi pasteur	Federally supported	Delete
120	DTaP-Hib-IPV	C3928AA	7/5/2013	sanofi pasteur	Federally supported	Delete
120	DTaP-Hib-IPV	C4059AA	7/5/2013	sanofi pasteur	Federally supported	Delete
120	DTaP-Hib-IPV	C3917AA	6/9/2013	sanofi pasteur	Federally supported	Delete
120	DTaP-Hib-IPV	C4130AA	6/9/2013	sanofi pasteur	Federally supported	Delete
120	DTaP-Hib-IPV	C4046AA	5/18/2013	sanofi pasteur	Supported by Private Insurance or Other Private Funds	Delete

1 2 3 4

Figure 6.15



In case there is no CIR number, enter the patient mother's maiden name, first name to assign/retrieve a number from the CIR. On checking the option "*Refresh Patient's Records after Submission*" (<6.18>), submit the immunization information is bidirectional updated and retrieve from the CIR and the two places have up to date immunization information.

**JOSEPH P ADDABBO FAMILY HLTH CNTR**

Home | Provider | Front Desk | Billing | Clerk | Reports | Control Panel

**Immunizations**

Acct#:                      Name:                      Sex:                      DOB:

#	Vaccine	Route	H	Given Date	VIS	Site	Lot #	Manufacturer	Expired On
1	DTaP-Hib-IPV	IM		07/31/2012	12/16/1998	Left Arm	C4116AA	PMC	2/18/2013
2	MMRV	SC	H	07/31/2012	03/13/2008	Left Thigh	1004AA	MSD	6/28/2013
3	Influenza, seasonal, injectable, preservative free	IM	H	07/31/2012	07/26/2011	Left Deltoid			

**Additional Patient's Information:**

Patient's CIR ID: 709363563 ☒ Refresh Patient's Record After Submission

Mother's Maiden Name: test\_maiden

Mother's First Name: test2\_maiden

<6.18>

< Back                      Confirm

Figure 6.17



### 4.3 Allergy:

This displays the patient's active and inactive allergies. Please select “*Show Inactive Allergy*” and refresh to view the inactive allergies (<6.20>). We can add new allergies by searching the name (at least 3 letters) in the textbox on the right side. The result is displayed below. (<6.21>). The most common allergies are already provided in the list on the right side of the page. Select the checkbox next to the name of the allergy and click on “*Add Allergy*”. (<6.22>)

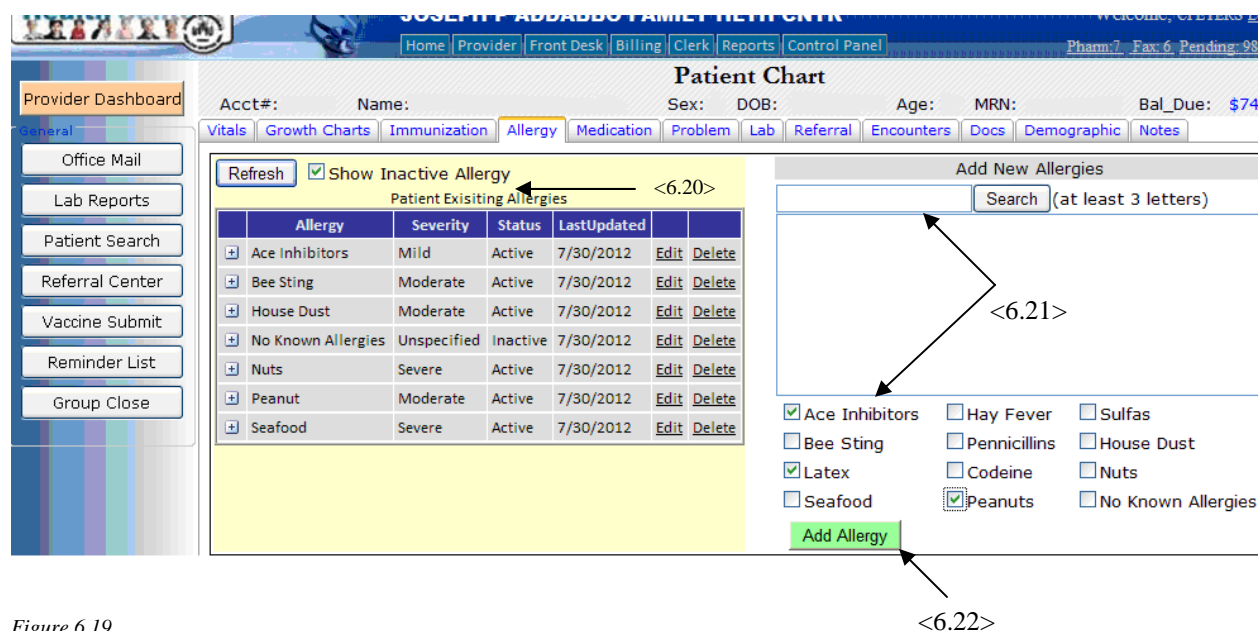


Figure 6.19

This displays a window to select the severity of the allergy and a textbox to add reaction or any additional information. Click on “*Save*” to save the allergy to the patient's chart (<6.24>)

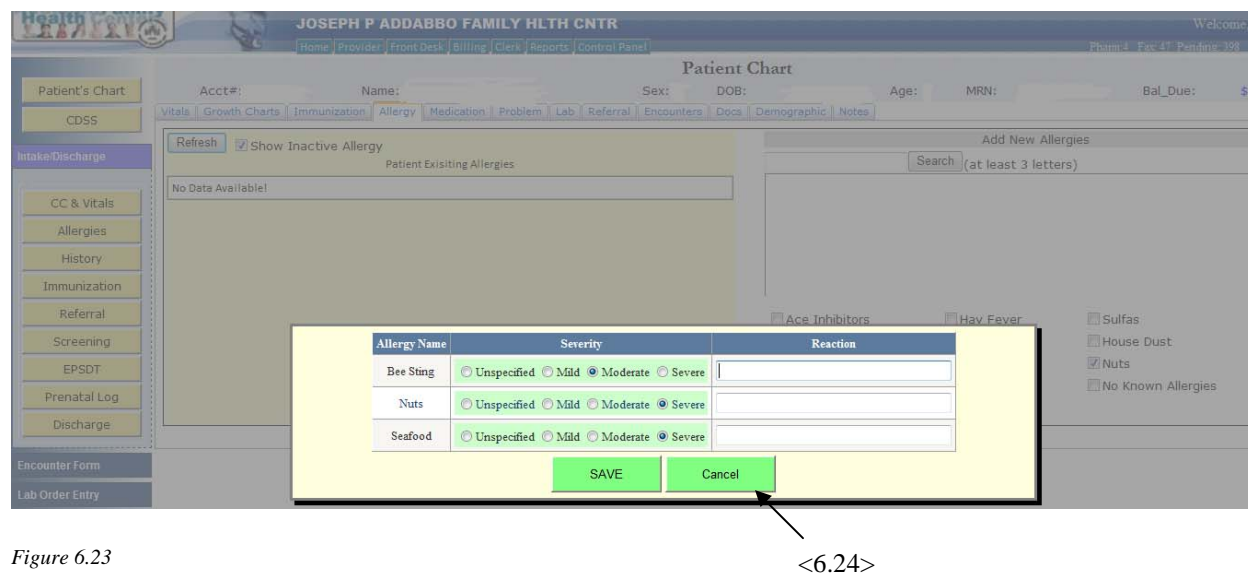


Figure 6.23

## 4.4 Medication:

This displays patient's active medications. Click on “*Refresh*” to update the medication list to the latest. To view inactive medication, select “*Show Inactive Medication*” and click “*Refresh*”. If the patient takes no active medication, please select the “*Patient Takes No Active Medication*” button. (<6.26>).

If the provider wishes to give the patient handouts containing more information about the medication, click on “*Handouts*” (<6.27>), which redirects to the “*Medline Plus*” website from where the provider can print and give the patient more information about their medication. See Figure 6.28.

**JOSEPH P ADDABBO FAMILY HLTH CNTR**

Home | Provider | Front Desk | Billing | Clerk | Reports | Control Panel

**Patient Chart**

Acct# \_\_\_\_\_ Name: \_\_\_\_\_ Sex: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ MRN: \_\_\_\_\_ Bal\_Due: \_\_\_\_\_

Vitals | Growth Charts | Immunization | Allergy | **Medication** | Problem | Lab | Referral | Encounters | Docs | Demographic | Notes

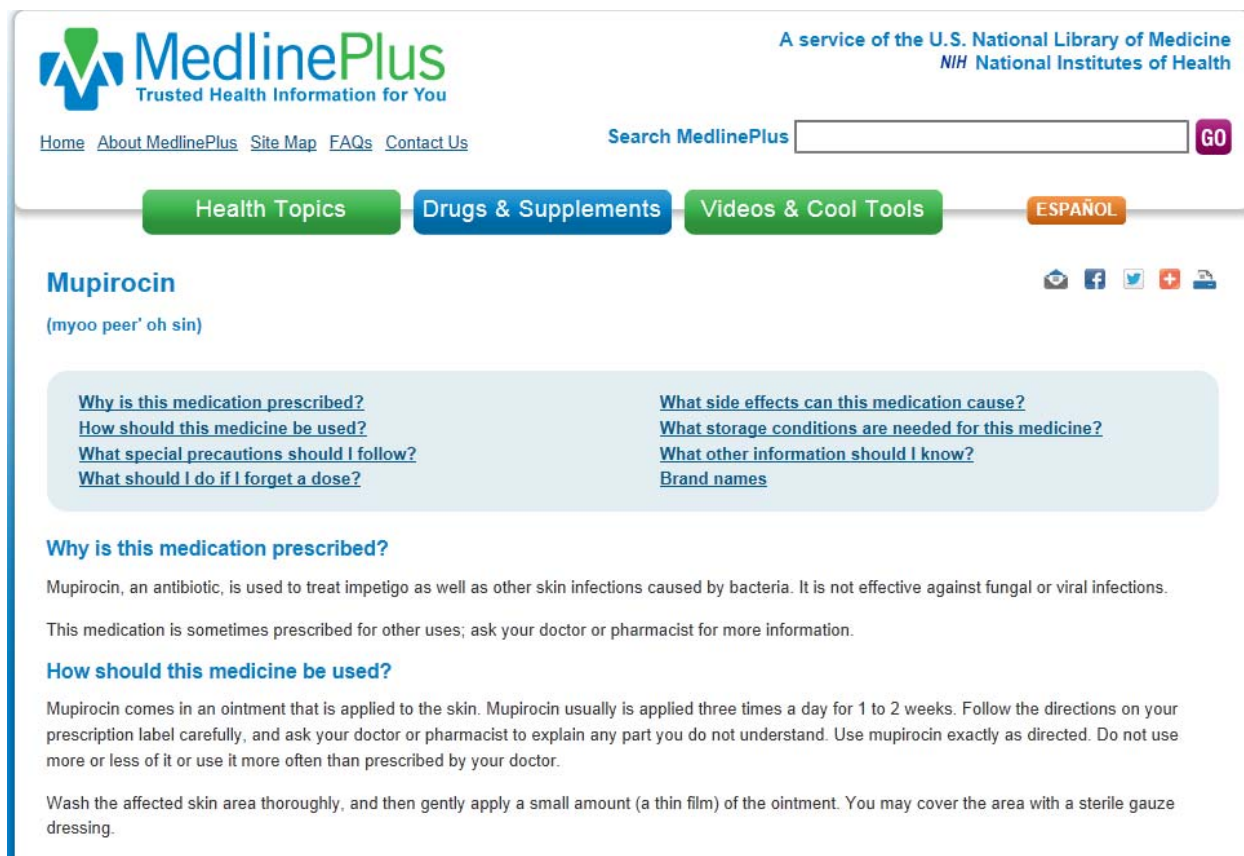
☒ Show Inactive Medication Last Update: 7/31/2012 9:44:12 AM (You have to refresh to see the latest medication list)

or

**Active Medication**

Date	Physician	DrugInfo	Dosage	Route	Freq	Dsp	DAW	PRN	Refills	Archive	Src	Handouts
4/28/2012	VELASQUEZ	Poly-Vi-Sol Oral Drops	<6.26>	by mouth	DAILY	1	N	N	5	N		<input type="button" value="Handouts"/>
4/3/2012	VELASQUEZ	mupirocin 2 % Ointment	1	apply on the skin	BID	1	N	N	0	N		<input type="button" value="Handouts"/>
4/3/2012	VELASQUEZ	hydrocortisone 2.5 % Ointment	1	apply on the skin	BID	1	N	N	0	N		<input type="button" value="Handouts"/>
8/4/2011	VELASQUEZ	acetaminophen 160 mg/5 mL Elixir	3	by mouth	Q4h	1	N	Y	0	N		<input type="button" value="Handouts"/>
11/11/2010	VELASQUEZ	acetaminophen 80 mg/0.8 mL Oral Syringe	0.5/half	by mouth	Q4h	1	N	N	0	N		<input type="button" value="Handouts"/>

Figure 6.25



The screenshot displays the MedlinePlus website interface. At the top left is the MedlinePlus logo with the tagline "Trusted Health Information for You". To the right, it states "A service of the U.S. National Library of Medicine" and "NIH National Institutes of Health". Below the logo is a navigation bar with links: Home, About MedlinePlus, Site Map, FAQs, and Contact Us. A search bar labeled "Search MedlinePlus" with a "GO" button is positioned to the right. Below the navigation bar are three main category buttons: "Health Topics" (green), "Drugs & Supplements" (blue), and "Videos & Cool Tools" (green). An "ESPAÑOL" button is also present. The main content area is titled "Mupirocin" with its pronunciation "(myoo peer' oh sin)". Below the title is a light blue box containing several links: "Why is this medication prescribed?", "How should this medicine be used?", "What special precautions should I follow?", "What should I do if I forget a dose?", "What side effects can this medication cause?", "What storage conditions are needed for this medicine?", "What other information should I know?", and "Brand names". The "Why is this medication prescribed?" section explains that Mupirocin is an antibiotic used for skin infections like impetigo. The "How should this medicine be used?" section describes the application of the ointment three times a day for 1 to 2 weeks, following the prescription label.

**MedlinePlus**  
Trusted Health Information for You

A service of the U.S. National Library of Medicine  
NIH National Institutes of Health

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## Mupirocin

(myoo peer' oh sin)

[Why is this medication prescribed?](#)  
[How should this medicine be used?](#)  
[What special precautions should I follow?](#)  
[What should I do if I forget a dose?](#)

[What side effects can this medication cause?](#)  
[What storage conditions are needed for this medicine?](#)  
[What other information should I know?](#)  
[Brand names](#)

### Why is this medication prescribed?

Mupirocin, an antibiotic, is used to treat impetigo as well as other skin infections caused by bacteria. It is not effective against fungal or viral infections.

This medication is sometimes prescribed for other uses; ask your doctor or pharmacist for more information.

### How should this medicine be used?

Mupirocin comes in an ointment that is applied to the skin. Mupirocin usually is applied three times a day for 1 to 2 weeks. Follow the directions on your prescription label carefully, and ask your doctor or pharmacist to explain any part you do not understand. Use mupirocin exactly as directed. Do not use more or less of it or use it more often than prescribed by your doctor.

Wash the affected skin area thoroughly, and then gently apply a small amount (a thin film) of the ointment. You may cover the area with a sterile gauze dressing.

Figure 6.28

## 4.5 Problem List:

This displays patient's active problem list. In order to view “*Resolved*” and “*Inactive*” problems, please select the fields and click on “*Refresh*”. In order to add a new problem, click on the “*Add New Problem*” button. (<6.30>)

**Patient Chart**

Acct#: Name: Sex: F DOB: Age: MRN: Bal\_Due: \$0.00

Vitals Growth Charts Immunization Allergy Medication **Problem** Lab Referral Encounters Docs Demographic Notes

No Active Problem Add New Problem Refresh ☒ Resolved ☒ Inactive

#	Dx Code	Problem Name	OnSet Date	Risk	Status	Changed On			H
1	477.9	ALLERGIC RHINITIS, CAUSE UNSPEC	6/26/2012			6/26/2012			
2	278.01	MORBID OBESITY	6/26/2012			6/26/2012			

Figure 6.29

&lt;6.30&gt;

Select the current ongoing diagnosis of the patient from the right side of the page to add the problem the diagnosis is related to. (<6.32>)

**Problem List**

Acct# Name: Sex: DOB: Age: MRN: Bal\_Due: \$74.5

No Active Problem Add New Problem Refresh ☐ Resolved ☐ Inactive

No Data Available.

Diagnosis Codes Within 12 months

Date	Dx1	Dx2	Dx3	Dx4
3/9/2012	474.10	268.9	493.90	782.1
2/24/2012	460	268.9		
2/21/2012	367.4			
2/16/2012	493.90			
2/8/2012	V74.1			
2/6/2012	V70.5	382.9	493.90	368.9

Figure 6.31

&lt;6.32&gt;


The provider can also search the diagnosis by keyword or by code and selecting the result from the dropdown list below the search box. Enter the risk, status and additional information in the detail box and click on the “Save” to add the problem to the list. (<6.34>)

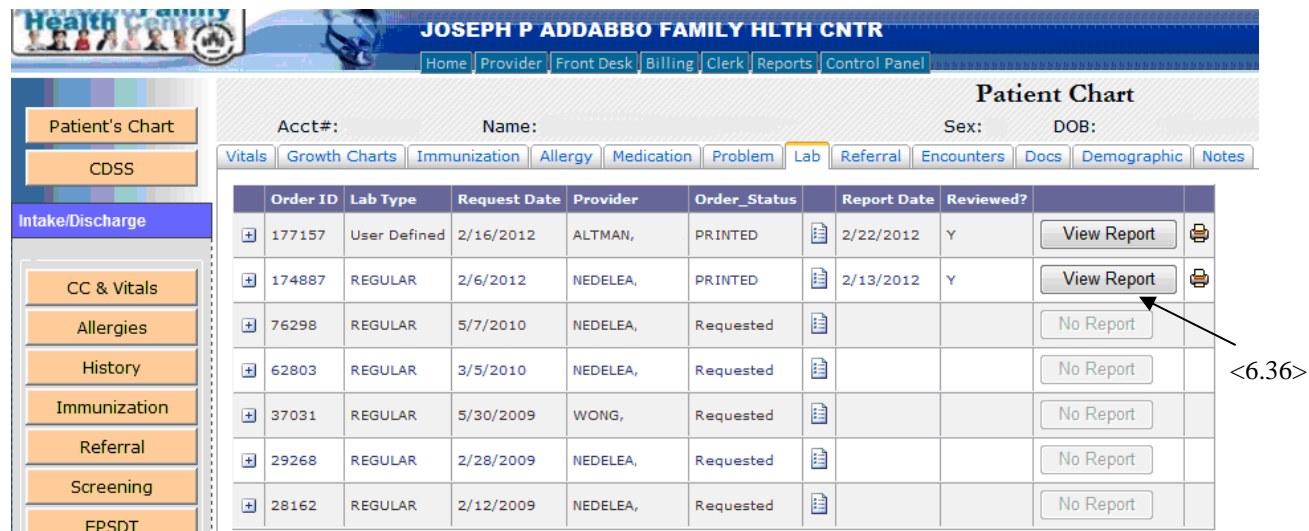
The screenshot displays a web-based form for entering medical data. At the top, there is a "Google Search" button and a "Search Dx" field containing "v76.2". Below this are two buttons: "By Keyword" and "By Code". A dropdown menu shows "----Click to Select----". The form then has several input fields: "OnSet\_Date" (8/24/2012), "Type" (Symptom), "Risk" (Medium), and "Status" (Active). The "Problem" field contains "HYPERTROPHY OF TONSIL WITH ADENOID". The "Detail" field contains "Detail testing". The "Dx\_code" field contains "474.10". The "Description" field contains "HYPERTROPHY OF TONSIL WITH ADENOID". At the bottom are "Save" and "Reset" buttons. A callout arrow points to the "Detail" field with the label "<6.34>".

Figure 6.33

## 4.6 Labs:

This displays the patient's previous lab reports ordered by any provider in Addabbo.

The provider can print the labs by clicking on the print icon . In order to view the labs click on "View Report" (<6.36>)





**JOSEPH P ADDABBO FAMILY HLTH CNTR**

Home | Provider | Front Desk | Billing | Clerk | Reports | Control Panel

**Patient Chart**

Acct#: Name: Sex: DOB:

Vitals | Growth Charts | Immunization | Allergy | Medication | Problem | Lab | Referral | Encounters | Docs | Demographic | Notes

Order ID	Lab Type	Request Date	Provider	Order_Status	Report Date	Reviewed?		
177157	User Defined	2/16/2012	ALTMAN,	PRINTED	2/22/2012	Y	View Report	
174887	REGULAR	2/6/2012	NEDELEA,	PRINTED	2/13/2012	Y	View Report	
76298	REGULAR	5/7/2010	NEDELEA,	Requested			No Report	
62803	REGULAR	3/5/2010	NEDELEA,	Requested			No Report	
37031	REGULAR	5/30/2009	WONG,	Requested			No Report	
29268	REGULAR	2/28/2009	NEDELEA,	Requested			No Report	
28162	REGULAR	2/12/2009	NEDELEA,	Requested			No Report	

<6.36>

Figure 6.35

**Lab Result Detail**

Acct#: 30481 Name: Sex: M DOB: Age: 11 MRN: Bal\_Due: \$74.55

Rpt On: 2/22/2012 2:03:41 PM Specimen Number: Rpt Status: FINAL

#	Test Name	ABN	Result	Units	Reference Range	Status
<b>A. FUMIGATUS (M3) IGE</b>						
1	A. FUMIGATUS (M3) IGE	N	<0.35	kU/L	<0.35	F
2	Class	N	0			F
<b>ALLERGEN A. ALTERNATA</b>						
1	A. ALTERNATA (M6) IGE	N	<0.35	kU/L	<0.35	F
2	Class	N	0			F
<b>BERMUDA GRASS (G2) IGE</b>						
1	BERMUDA GRASS (G2) IGE	N	<0.35	kU/L	<0.35	F
2	Class	N	0			F
<b>BIRCH (T3) IGE</b>						
1	BIRCH (T3) IGE	N	<0.35	kU/L	<0.35	F
2	Class	N	0			F
<b>C. HERBARUM (M2) IGE</b>						
1	C. HERBARUM (M2) IGE	N	<0.35	kU/L	<0.35	F
2	Class	N	0			F
<b>CAT EPITH/DANDER(E1) IGE</b>						
1	CAT DANDER (E1) IGE	N	<0.35	kU/L	<0.35	F
2	Class	N	0			F
<b>COCKROACH (I6) IGE</b>						
1	COCKROACH (I6) IGE	N	<0.35	kU/L	<0.35	F
2	Class	N	0			F

Review Date: 2/28/2012 Reviewed By: ALTMAN

Adding New Comments Below:

Buttons: Print, View Lab Hx, Mark as Reviewed, Flag It, Patient's Chart, Back

<6.38>

Figure 6.37

Each test result is color coded based on its abnormality in case of high/low. You can also view the trend by clicking the icon with the similar previous tests if ordered. There is a symbol which indicates as an important message from Quest to the provider regarding the test.

The provider is advised to put in the comments and when reviewed click on “Mark as Reviewed”. If the provider wishes to check on a pending item/ or recall the patient, click on “Flag It” to add this patient’s lab to the flagged list. (<6.38>)

Click on “View Lab Hx” to view previous lab histories. (Figure 6.39)

**Lab Result Detail**

Acct#: 30481 Name: Sex: M DOB: Age: 11 MRN: Bal\_Due: \$74.55





Selected Lab Detail: 02/22/2012 02/13/2013

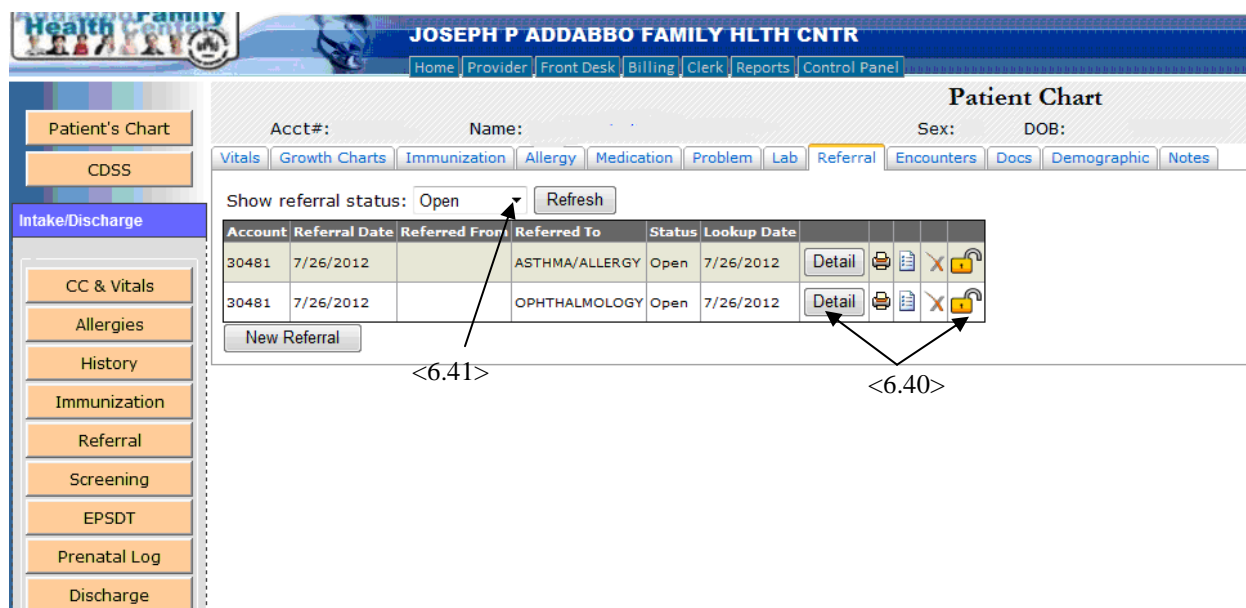
Analyte Name	Result	Units
A. FUMIGATUS (M3) IGE	<0.35	kU/L
Class	0	
A. ALTERNATA (M6) IGE	<0.35	kU/L
BERMUDA GRASS (G2) IGE	<0.35	kU/L
BIRCH (T3) IGE	<0.35	kU/L
C. HERBARUM (M2) IGE	<0.35	kU/L
CAT EPITH/DANDER(E1) IGE	<0.35	kU/L
COCKROACH (I6) IGE	<0.35	kU/L
COMMON PIGWEED (W14) IGE	<0.35	kU/L
COMMON RAGWEED (W1) IGE	<0.35	kU/L
COTTONWOOD (T14) IGE	<0.35	kU/L
D. FARINAE (D2) IGE	<0.35	kU/L

Figure 6.39



## 4.7 Referrals:

This displays the referral from one provider to another. Click on “*Detail*” to view the referral request, description and information about the referring provider and the referred provider (Figure 6.42). Click on the “*Print*” icon  to print the referral. If you would like to view the referral report once the patient has seen the provider, then click on the “*Note*” icon  which redirects to a page that allows you to view the report or even upload the referral report. To delete a referral, click on the  icon. If you would like to lock the details of the referral, then click on the lock icon . (<6.40>). “*Show Referral Status*” drop down allows choosing open, closed, in process, or reviewed referrals. (<6.41>)



Health Family

JOSEPH P ADDABBO FAMILY HLTH CNTR

Home Provider Front Desk Billing Clerk Reports Control Panel

Patient's Chart

CDSS

Intake/Discharge

CC & Vitals

Allergies

History

Immunization

Referral

Screening

EPSDT









Prenatal Log

Discharge

Acct#: Name: Sex: DOB:

Vitals Growth Charts Immunization Allergy Medication Problem Lab Referral Encounters Docs Demographic Notes

Show referral status: Open Refresh

Account	Referral Date	Referred From	Referred To	Status	Lookup Date	Detail	Print	Note	Delete	Lock
30481	7/26/2012		ASTHMA/ALLERGY	Open	7/26/2012	Detail				
30481	7/26/2012		OPHTHALMOLOGY	Open	7/26/2012	Detail				

New Referral

<6.41>

<6.40>

Figure 6.40



JOSEPH P ADDABBO FAMILY HLTH CNTR

Home Provider Front Desk Billing Clerk Reports Control Panel

Patient Referral

Acct#: Name: Sex: DOB:

Show referral status: Open Refresh

No referral found on the selected status.

New Referral

Ref\_Date: 7/26/2012 Ref\_#: Status: Open

LookUp: 7/26/2012 Ins\_ID:

Payer: COMPUTER SCIENCE CORP

"Referring From" Physician

Name: AM\_AKHAND

Phone: 666-666-6666 Fax: Email:

Contact: AM\_AKHAND

"Referred To" Physician/office

Name: IRF\_ASTHMA/ALLERGY

Phone: 000-000-0000 Fax: Email:

Contact:

Referral Description:

Dx\_Code:

Save

<6.44>

<6.43>

Figure 6.42

The picture above shows the details of the referral. Click on “Details” on the referral page (<6.40>). Select a provider from the drop down list. (<6.43>)

### 4.7.1 New Referral:

To add a new referral, click on “*New Referral*” in the above page. (<6.44>). This directs to a page, where we have a list of internal referring providers/external providers.

Check the box next to the department in which you would like to refer the patient to. On the right side of the page, enter the appropriate referral description. (<6.46>)

JOSEPH P ADDABBO FAMILY HLTH CNTR

Home Provider Front Desk Billing Clerk Reports Control Panel Pharm

Patient's Chart  
CDSS  
Intake/Discharge  
CC & Vitals  
Allergies  
History  
Immunization  
Referral  
Screening  
EPSDT

Acct#: Name: Sex: DOB: Age: MRN:

< Back Select List: REGULAR

Internal External

☐ ADULT ☐ NEUROLOGY ☐ PODIATRY  
☒ ASTHMA/ALLERGY ☐ NUTRITION ☒ PSYCHIATRY  
☒ CARDIOLOGY ☐ OB/GYN ☐ PSYCHOLOGY  
☐ DENTAL ☒ OPHTHALMOLOGY ☐ RYAN WHITE  
☐ DERMATOLOGY ☐ PEDIATRICS ☐ UROLOGY  
☐ ENDOCRINOLOGY ☐ PHYSICAL THERAPY

Referral Description:  
Payor:   
Dx\_Code: 474.10 Ref\_# LookUp\_Date: 7/31/2012  
Diagnosis: HYPERTROPHY OF TONSIL WITH ADENOIDS  
Detail:   
Save

<6.46>

Figure 6.45

The “*External*” tab allows you to refer a patient to a different clinic or hospital outside of Addabbo. Check the box next to the name of the clinic/hospital as shown below. (<6.48>)

JOSEPH P ADDABBO FAMILY HLTH CNTR

Home Provider Front Desk Billing Clerk Reports Control Panel Pharm

Patient's Chart  
CDSS  
Intake/Discharge  
CC & Vitals  
Allergies  
History  
Immunization  
Referral  
Screening  
EPSDT

Acct#: Name: Sex: DOB: Age: MRN:

< Back Select List: REGULAR


Internal External

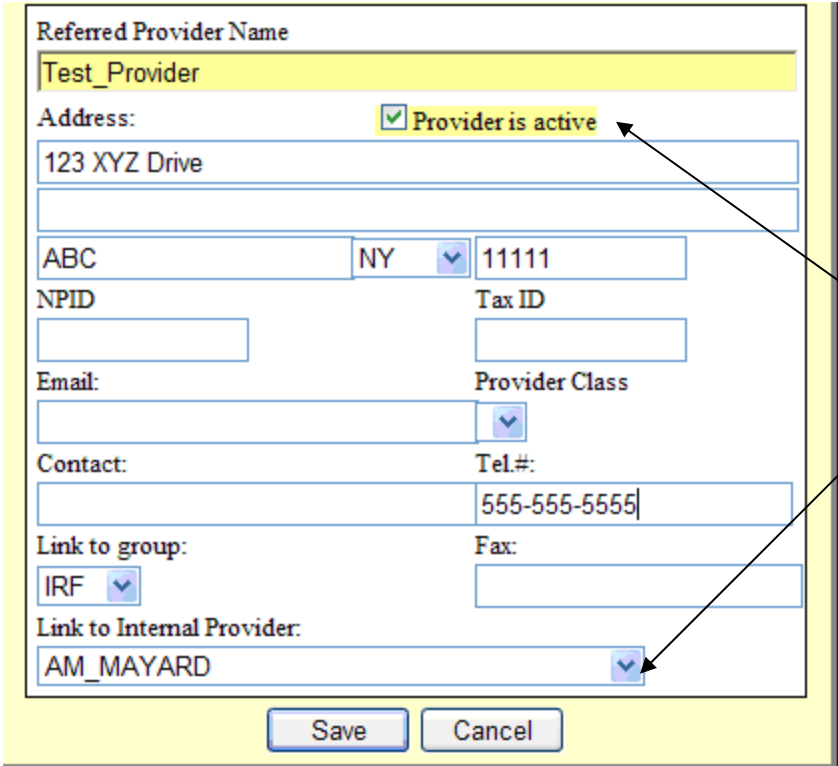
☒ Queens Hospital ☐ St. Johns Hospital

Referral Description:  
Payor:   
Dx\_Code: 474.10 Ref\_# LookUp\_Date: 7/31/2012  
Diagnosis: HYPERTROPHY OF TONSIL WITH ADENOIDS  
Detail:   
Save

<6.48>

Figure 6.47

In order to add more external referring providers to the list, click on the  icon. Fill in the appropriate information. The referring provider can have names like “*Queens Hospital*” or “*Queens Hospital-Radiology*”, etc. Make sure the “*Provider Is Active*” checkbox is checked in order to appear in the list. We can also link this referring provider to an internal Addabbo provider by selecting the provider’s name from the dropdown of “*Link to Internal Provider*” (<6.50>)



Referred Provider Name

Test\_Provider

Address: ☒ Provider is active

123 XYZ Drive

ABC NY 11111

NPID Tax ID

Email: Provider Class

Contact: Tel.#: 555-555-5555

Link to group: IRF


Link to Internal Provider: AM\_MAYARD

Save Cancel

<6.50>

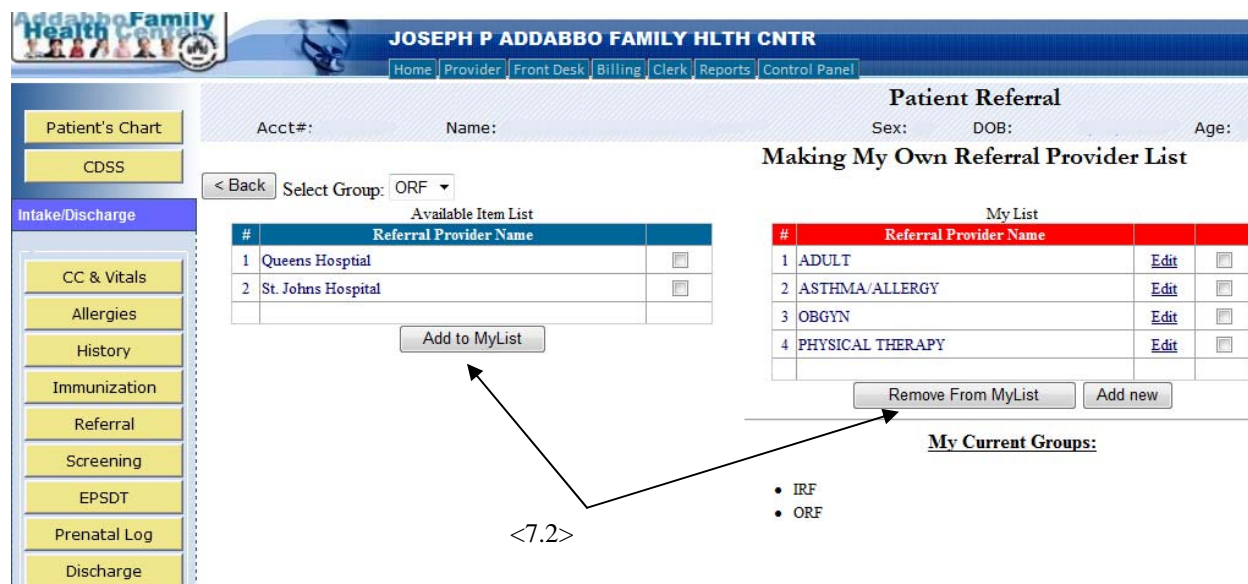
Figure 6.49

### 4.7.2 Create Custom Referring Provider List:

Click on the  icon to add custom referring provider. We can create both internal (by selecting IRF group) and outside providers (by selecting the ORF group).

Check the provider in the list to add to the group and click on “Add to my list”

We can also remove the provider from the list, select the provider and click on “Remove from My List”. Click on “Add new” to add new referring provider to IRF/ ORF list. (<7.2>)



**JOSEPH P ADDABBO FAMILY HLTH CNTR**

Home | Provider | Front Desk | Billing | Clerk | Reports | Control Panel

**Patient Referral**

Acct#: Name: Sex: DOB: Age:

**Making My Own Referral Provider List**

< Back Select Group: ORF

Available Item List

#	Referral Provider Name	
1	Queens Hospital	<input type="checkbox"/>
2	St. Johns Hospital	<input type="checkbox"/>

Add to MyList

My List

#	Referral Provider Name	Edit	
1	ADULT	Edit	<input type="checkbox"/>
2	ASTHMA/ALLERGY	Edit	<input type="checkbox"/>
3	OBGYN	Edit	<input type="checkbox"/>
4	PHYSICAL THERAPY	Edit	<input type="checkbox"/>

Remove From MyList Add new

**My Current Groups:**


- IRF
- ORF

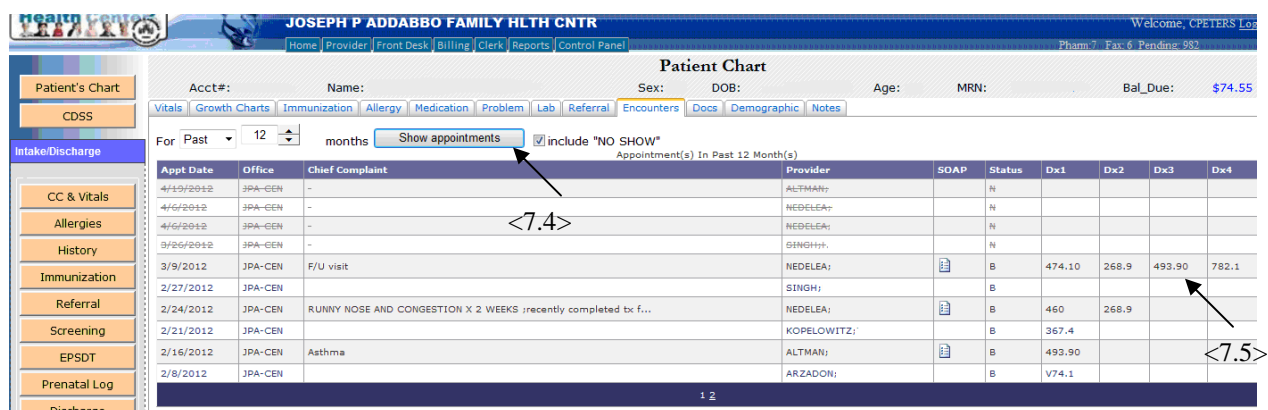
<7.2>

Figure 7.1

## 4.8 Encounters:

This displays the patient's previous encounters over the selected period. Please select the time span (e.g. 12 months) and click on “*Show Appointments*”. You can check “*Include No Show*” to view the appointments that the patient missed. (<7.4>)

The result list also contains the patient's previous visit SOAP notes (if the notes are added to the chart) to view. Click on the  icon to view the SOAP notes of that visit. The page also displays the diagnosis of the patient. On moving the mouse over the Dx, the provider can view the description of the diagnosis code.






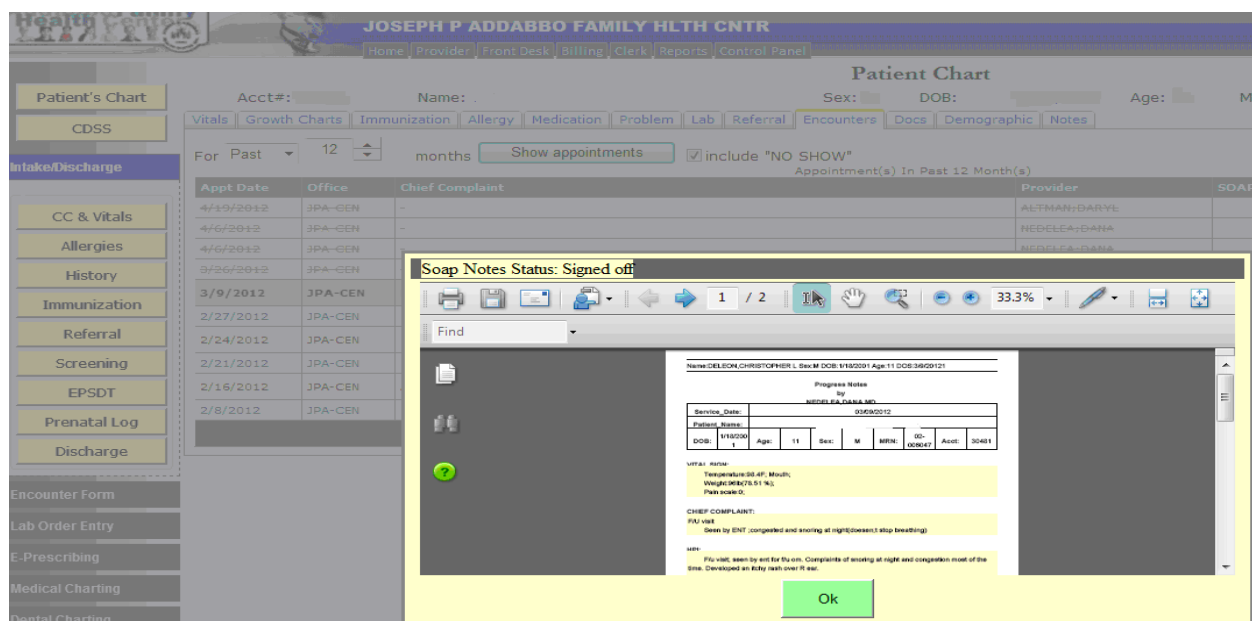
Appt Date	Office	Chief Complaint	Provider	SOAP	Status	Dx1	Dx2	Dx3	Dx4
4/19/2012	JPA-CEN	-	ALTMAN;		N				
4/6/2012	JPA-CEN	-	NEDELEA;		N				
4/6/2012	JPA-CEN	-	NEDELEA;		N				
3/26/2012	JPA-CEN	-	SINGH;		N				
3/9/2012	JPA-CEN	F/U visit	NEDELEA;		B	474.10	268.9	493.90	782.1
2/27/2012	JPA-CEN	-	SINGH;		B				
2/24/2012	JPA-CEN	RUNNY NOSE AND CONGESTION X 2 WEEKS ;recently completed tx f...	NEDELEA;		B	460	268.9		
2/21/2012	JPA-CEN	-	KOPELOWITZ;		B	367.4			
2/16/2012	JPA-CEN	Asthma	ALTMAN;		B	493.90			
2/8/2012	JPA-CEN	-	ARZADON;		B	V74.1			

Figure 7.3






Appt Date	Office	Chief Complaint	Provider	SOAP
4/19/2012	JPA-CEN	-	ALTMAN-DARYL	
4/6/2012	JPA-CEN	-	NEDELEA-DANA	
4/6/2012	JPA-CEN	-	NEDELEA-DANA	
3/26/2012	JPA-CEN	-	NEDELEA-DANA	
3/9/2012	JPA-CEN	F/U visit	NEDELEA;	
2/27/2012	JPA-CEN	-	SINGH;	
2/24/2012	JPA-CEN	RUNNY NOSE AND CONGESTION X 2 WEEKS ;recently completed tx f...	NEDELEA;	
2/21/2012	JPA-CEN	-	KOPELOWITZ;	
2/16/2012	JPA-CEN	Asthma	ALTMAN;	
2/8/2012	JPA-CEN	-	ARZADON;	

Figure 7.6

## 4.9 Docs:

The provider can view various patient related documents in this section. These documents can be either the patient referral report, imaging report etc. Select the category of the document in the “*Select Document Category*” dropdown. Click on “*View*” to view the document on the left side of the page. (<7.8>)

We can also upload the file by clicking on browse, selecting the pdf document and then click on “*Load File*”. Please add more comments regarding the document, the document title, and selecting the category and then click “*Save*” to save the document into the system in the right category. (<7.9>)

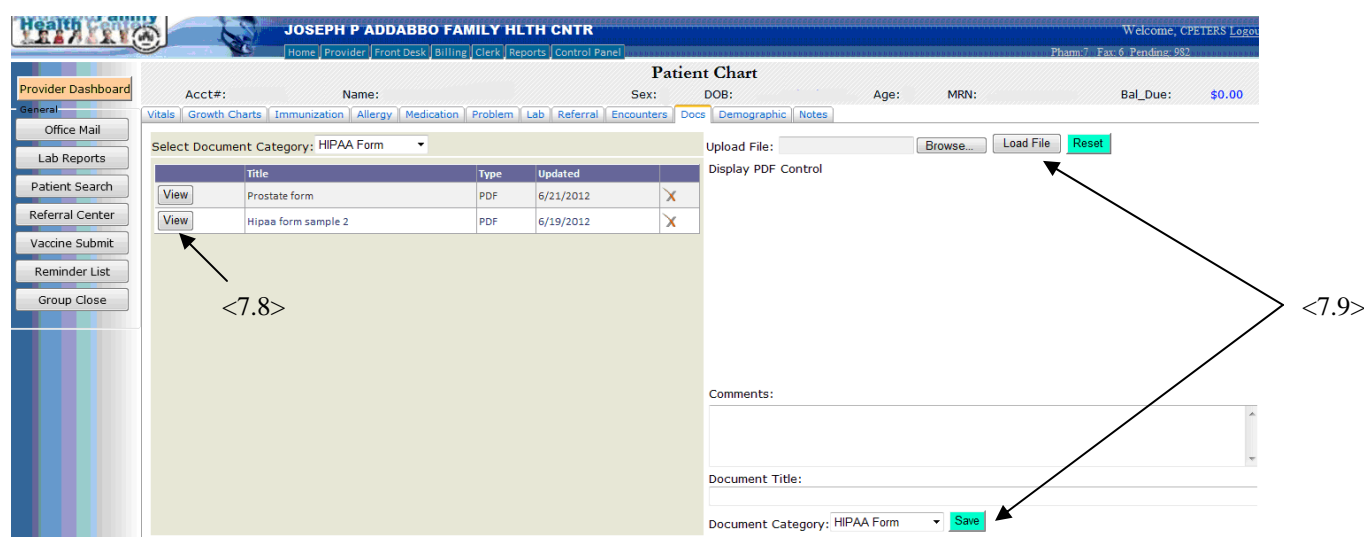


Figure 7.7

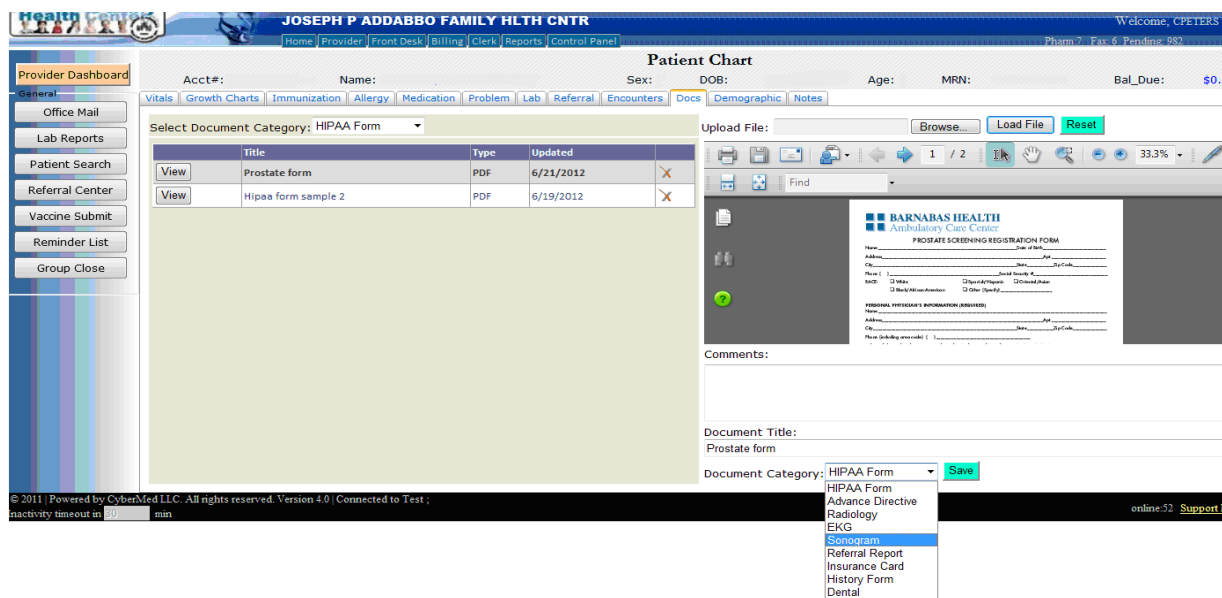


Figure 7.10

## 4.10 Demographics:

This displays patient's demographic information. We can add/change the information and click on "Save" to register saved changes to the system. (<7.12>)

The screenshot shows the 'Patient Chart' interface for 'JOSEPH P ADDABBO FAMILY HLTH CNTR'. The 'Demographic' tab is selected. The form contains the following fields:

- Account: 30481
- MRN: 00-000000
- Contact: Home 5555555555
- First Name: PATIENT
- Last Name: TEST
- Primary: 7777777777
- Address: ABC DRIVE
- City: XYZ, State: NY, Zip: 11111
- DOB: 12/12/2012
- Sex: Male (selected)
- SSN: 000000000
- Communication Pref.: PHONE
- Appointment Alert: (empty)
- Billing Alert: (empty)
- Service Provider: (dropdown)
- Smoke Status: (dropdown)

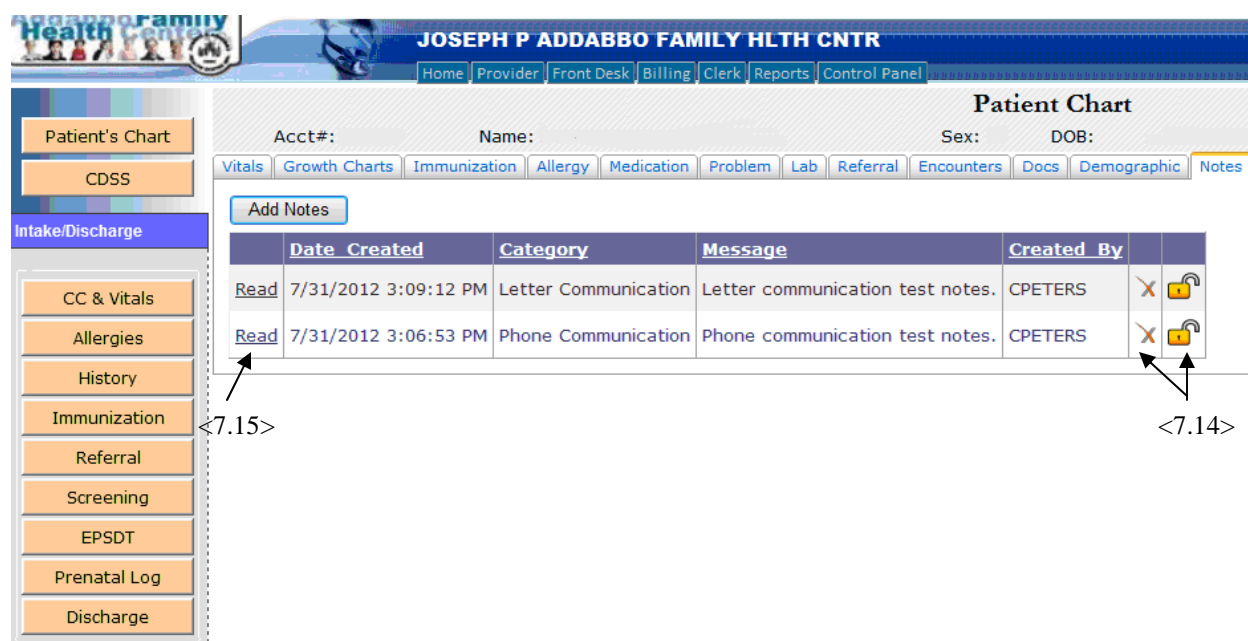
At the bottom of the form are 'Save' and 'Reset' buttons. An arrow points to the 'Save' button, which is labeled with the text '<7.12>'.

Figure 7.11

<7.12>

#### 4.11 Notes:

In this section, the provider can record/send out notes about the patient/to the patient by clicking on “Add Notes”. The notes can be either the phone communication notes or the letter communication notes. You can delete the notes by clicking on the “X” on the right side of the page, or you can lock your notes by clicking on the lock icon (<7.14>). Once a note is locked, the provider won’t be able to make any other changes to it. Click on “Read” to read notes. (<7.15>)



**JOSEPH P ADDABBO FAMILY HLTH CNTR**





Home | Provider | Front Desk | Billing | Clerk | Reports | Control Panel

**Patient Chart**

Acct#:      Name:      Sex:      DOB:

Vitals | Growth Charts | Immunization | Allergy | Medication | Problem | Lab | Referral | Encounters | Docs | Demographic | **Notes**

[Add Notes](#)

	Date Created	Category	Message	Created By	
<a href="#">Read</a>	7/31/2012 3:09:12 PM	Letter Communication	Letter communication test notes.	CPETERS	 
<a href="#">Read</a>	7/31/2012 3:06:53 PM	Phone Communication	Phone communication test notes.	CPETERS	 

<7.15>      <7.14>

Figure 7.13



**Patient Chart**

Acct#:      Name:      Sex:      DOB:     

Vitals | Growth Charts | Immunization | Allergy | Medication | Problem | Lab | Referral | Encounters | Docs | Demographic | Notes

Add Notes

	Date Created	Category	Message	Created By
Read	7/31/2012 3:09:12 PM	Letter Communication	Letter communication test notes.	CPETERS
Read	7/31/2012 3:06:53 PM	Phone Communication	Phone communication test notes.	CPETERS

Note Detail:

Category: Letter Communication

Letter communication test notes.

SAVE Cancel

Figure 7.16

## 5.0 Intake/Discharge:

### 5.1 CC & VITALS:

This page is to record patient's chief complains and vital information. You can also use "SmartNotes Tool" to select the information regarding the patient (<8.2>, <8.9>). On clicking on "Save" this information is added to the chief complaints.

This page also contains various tabs to register "*Pain Assessment, Urine Dipstick, and Smoke Cessation*". (<8.3>).

If the patient has any complaints about aches and pains, enter it into "*Pain Assessment*", then select on a scale of 1 to 10 to register the measure of pain the patient is in. (<8.4>)

Once all the information is entered/ selected, please click on the "Save" button to save this information into the system.

We can also review the vital summary and the growth chart from this page by selecting the tabs in the page. (<8.5>, <8.6>, <8.7>)

**JOSEPH P ADDABBO FAMILY HLTH CNTR** Welcome, CPETERS Logout

Home Provider Front Desk Billing Clerk Reports Control Panel Pharm 7 Fax 6 Pending 931

**Vital Intake**

Acct#: \_\_\_\_\_ Name: \_\_\_\_\_ Sex: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ MRN: \_\_\_\_\_ Bal\_Due: \$0.00

[New Vitals](#) [Vitals Summary](#) [Growth Charts](#)

Physical Therapy  <8.2>

**Chief Complaint:**

This visit is Follow-up test <8.5>

**Complaint Detail:**

1. Patient complains pain at Head; Lower Back; Wrist Hand (L); Hip/Thigh (L); Knee (R); and 2. Patient feels Numbness; Tingling; Stiffness; Tremors; Weakness; and 3. Patient says Test Complaints

**Vital Signs:**

☒ English ☐ Metric

RR: 16 /min      Glucose: 187 mg/dL      Sa O2: 10 %

Pulse: 43 /min      Hgb: 55      ☒ RA ☐ O2 16 L/min

Height: 150 inch      BP: 120 / 150      hCG: Positive      Peak Flow: 10 L/min

Weight: 140 lb 2240 oz      Temp: 99 F Mouth      LMP: 06/20/2012      HIV Test: Accepted

HC: 10 cm      BSA: 56 m2      PMP: 06/25/2012      Captured on: 10:00 AM

BMI: 12

**Comments:**

<8.3>

[Pain Assessment](#) [Urine Dipstick](#) [Smoke Cessation](#)

**Pain Assessment:**

Location: Knee

Duration: 2 weeks

Frequency: 3/w

What helps:

**Pain Scale**

0 No Pain 1 2 3 4 5 6 7 8 9 10 Worst Possible

6

<8.4>

Figure 8.1

**Comments:**

Testing Comments

[Pain Assessment](#) [Urine Dipstick](#) [Smoke Cessation](#)

Leukocytes:	Trace	Blood:	2+
Nitrite:	Positive	SpcG:	1.010
Uro:	1.0 mg/dL	Ketone:	15 mg/dL
Protein:	Trace	Bilirubin:	2+
pH:	6.0	Glucose:	100 mg/dL

Figure 8.6

**Comments:**

Testing Comments

[Pain Assessment](#) [Urine Dipstick](#) [Smoke Cessation](#)

**Smoking Status:**

**Smoking Cessation:**

Tobacco use: ☒ Advice Given: ☒ Ready to Quit: ☒ Referral Made: ☒ Rx Given: ☒

Figure 8.7

**JOSEPH P ADDABBO FAMILY HLTH CNTR**

Home | Provider | Front Desk | Billing | Clerk | Reports | Control Panel

**Vital Intake**

Acct#: Name: Sex: DOB:

Smart Notes: Physical Therapy CC

a. Visit type: ☐ Initial Physiatry Evaluation ☒ Follow-up

b. Patient's pain on:

☒ Head ☐ Pelvis/Groin ☐ Shoulder (R) ☒ Wrist Hand (L) ☐ Knee (L)

☐ Face ☐ Upper Back ☐ Arm (L) ☐ Wrist Hand (R) ☒ Knee (R)

☐ Neck ☒ Lower Back ☐ Arm (R) ☒ Hip/Thigh (L) ☐ Ankle Foot (L)

☐ Chest ☐ Sacrum ☐ Elbow (L) ☐ Hip/Thigh (R) ☐ Ankle Foot (R)

☐ Abdomen ☐ Shoulder (L) ☐ Elbow (R)

c. Patient feels:

☒ Numbness ☐ Swelling ☒ Stiffness ☐ Rigidity ☒ Weakness

☒ Tingling ☐ Redness ☐ Spasticity ☒ Tremors ☐ Gait Deviation

d. Other complaints: Testing Vital Comapplaints

Save Cancel

Figure 8.9

## 5.2 Allergies:

Described in the previous section. Click here to view.

## 5.3 History:

This page allows you to view the patient's Medical History (PMHX), patient's Family History (Family Hx), Social History, Birth History, OBGYN History, and Functional History (<8.11>).

**JOSEPH P ADDABBO FAMILY HLTH CNTR**

Home | Provider | Front Desk | Billing | Clerk | Reports | Control Panel | Help

**Patient History**

Acct#: Name: Sex: DOB:

PMHX | Family Hx | Social Hx | Birth Hx | OBGYN Hx | Functional Hx



☐ Show Inactive Items

Visit	Brief Hx	LastUpdated	User
12/17/2012	Others: THYROID PROB...	12/17/2012	SDHOLAKIA

<8.13> <8.12>

Figure 8.10

## 5.4 Patient Medical History (PMHX):

To view inactive items under the history tab, check the “*Inactive Items*” check box and click on the refresh  button to refresh the list (<8.12>). To see more details about the patient’s history, click on the  button to view comments that the provider entered (<8.13>). Click on “*View Hx History*” icon to view the patient’s notes/history (<8.15>).

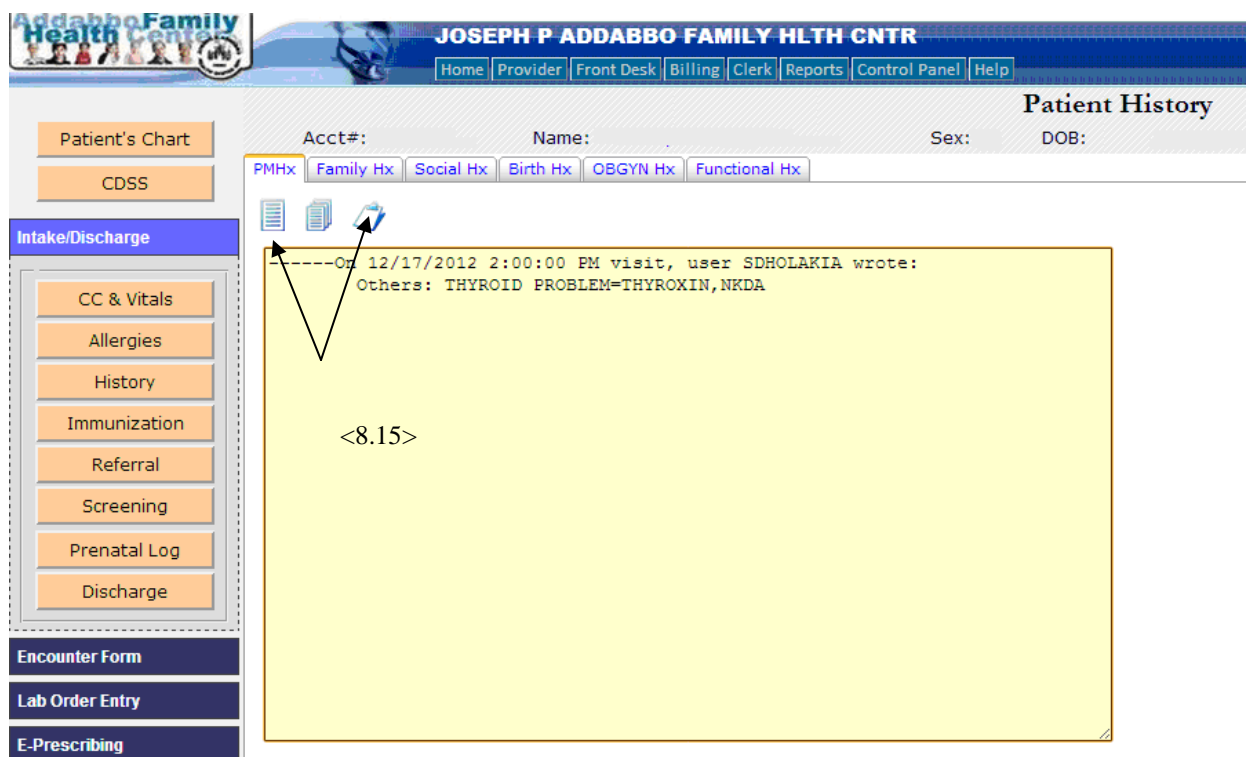


Figure 8.14

Click on the “*Create New Hx*” to create a new medical history (<8.15>). A list of the most common problems is on the right side of the page, if the problem is not present on the list, select “*Others*” and click on the “*Select and Edit Comments*” (<8.17>). A pop up box will appear where the user can add more comments about the problem (Figure 8.18). Simply click the “*Insert*” button to save the problem (<8.19>). The user can also manually type in their notes in the blank space box that is available for free typing (<8.20>).

Figure 8.16

#	Problem Name	Comments
1	Hepatitis	Testing_Hep
2	Hospitalizations	Testing_Hospitalizations
3	HyperTension	Testing_Hypertension
4	MI	Testing_MI
5	OA	Testing_OA
6	Rheumatic Fever	Testing_Rheumatic Fever
7	Taking Oral Contraceptives	Testing_Oral Contraceptives
8	TB	Testing_TB

<8.20>

<8.19>

Figure 8.18

To make it easier for the user to enter notes into the notes box, simply click on the “*Smart Notes Tool*” button. A series of questions will appear, fill out the appropriate sections and click on the “*Generate SmartNotes*” button.

**JOSEPH P ADDABBO FAMILY HLTH CNTR**  
[Home](#) [Provider](#) [Front Desk](#) [Billing](#) [Clerk](#) [Reports](#) [Control Panel](#) [Help](#)

**Patient History**  
 Acct#: \_\_\_\_\_ Name: \_\_\_\_\_ Sex: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
[PMHx](#) [Family Hx](#) [Social Hx](#) [Birth Hx](#) [OBGYN Hx](#) [Functional Hx](#)

**Past Medical History:**  
 Previous Physician's name:  Date of last exam:   
 Other SPECIALISTS currently seeing:   
 Infections: ☐ Yes ☒ No If yes, detail:   
 Sexually transmitted disease: ☐ Yes ☒ No If yes, detail:   
 Blood Transfusions: ☐ Yes ☒ No If yes, detail:

**Check the following conditions patient is currently being treated or have been treated for in the past:**

<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> RA
<input type="checkbox"/> CA	<input type="checkbox"/> HIV Exp.	<input type="checkbox"/> Problem w/ Behavior	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> CAD	<input type="checkbox"/> Hospitalizations	<input type="checkbox"/> Problem w/ Eating	<input type="checkbox"/> Smoking
<input type="checkbox"/> COPD	<input type="checkbox"/> HyperTension	<input type="checkbox"/> Problem w/ Growth	<input type="checkbox"/> Surgery
<input type="checkbox"/> CVA	<input checked="" type="checkbox"/> MI	<input checked="" type="checkbox"/> Problem w/ Sleeping	<input checked="" type="checkbox"/> Taking Oral Contraceptives
<input type="checkbox"/> Diabetes	<input checked="" type="checkbox"/> OA	<input type="checkbox"/> Problem w/ Speech	<input checked="" type="checkbox"/> TB
<input type="checkbox"/> Etoh & Drug Abuse	<input checked="" type="checkbox"/> Others	<input type="checkbox"/> Problem w/ Toilet Training	<input type="checkbox"/> Trauma
<input type="checkbox"/> Heart Murmur	<input checked="" type="checkbox"/> Pneumonia		

**Preventive Care (Approximate date of last, or provide copy of immunization record):**

Pneumonia <input type="text"/>	Influenza (flu) <input type="text"/>	Flexible Sigmoidoscopy/Colonoscopy <input type="text"/>
Tetanus Booster <input type="text"/>	Zoster (Shingles) <input type="text"/>	Bone Densitometry <input type="text"/>
Hepatitis <input type="text"/>		
Last Tuberculosis (TB) Screening? <input type="text"/>	Result of TB screening: <input type="checkbox"/> Positive <input checked="" type="checkbox"/> Negative	
If positive TB screen, date of last chest x-ray: <input type="text"/>	Result of chest x-ray: <input type="checkbox"/> Positive <input checked="" type="checkbox"/> Negative	


**Hospitalizations and Surgeries:**  
 Have you ever been hospitalized? ☐ Yes ☒ No if yes, what for:   
 Operations/Injuries without Hospitalization: ☐ Yes ☒ No if yes, what for:

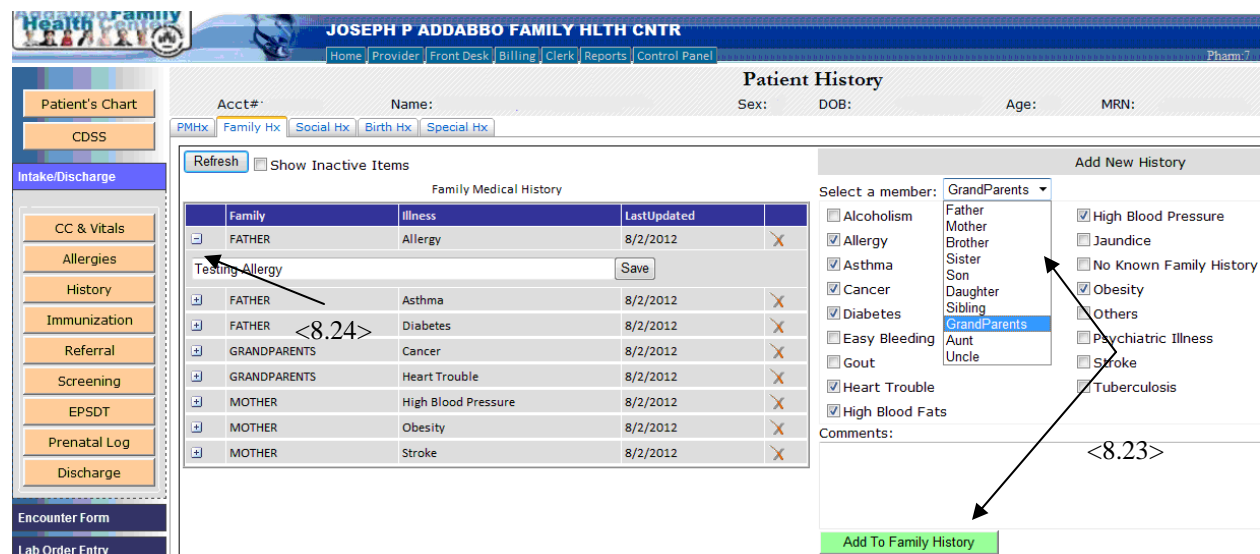
**Female Only:**  
 How many times have you been pregnant?   
 Date of last Pap Smear:  Have you had an abnormal Pap smear? ☐ Yes ☒ No  
 If yes, what was treatment?   
 Date of last mammogram?  Have you ever had an abnormal mammogram? ☐ Yes ☐ No  
 Have you ever had a breast biopsy? ☐ Yes ☒ No If yes, results:

☐ Overwrite ☒ Append

Figure 8.21

## 5.5 Family History:

Select the family member from the drop down list and check the checkbox next to the problem. Click on the “Add to Family History” button to add the problem to the list (<8.23>). In case of more problems or comments/description, click on the  icon to add more comments (<8.24>).



**JOSEPH P ADDABBO FAMILY HLTH CNTR**

Home | Provider | Front Desk | Billing | Clerk | Reports | Control Panel | Pharm 7


**Patient History**

Acct#: Name: Sex: DOB: Age: MRN:

PMHx | **Family Hx** | Social Hx | Birth Hx | Special Hx

Refresh ☐ Show Inactive Items


**Family Medical History**

Family	Illness	LastUpdated
FATHER	Allergy	8/2/2012
Testing Allergy  Save		
FATHER	Asthma	8/2/2012
FATHER	Diabetes	8/2/2012
GRANDPARENTS	Cancer	8/2/2012
GRANDPARENTS	Heart Trouble	8/2/2012
MOTHER	High Blood Pressure	8/2/2012
MOTHER	Obesity	8/2/2012
MOTHER	Stroke	8/2/2012

**Add New History**

Select a member: GrandParents



- ☐ Alcoholism
- ☒ Allergy
- ☒ Asthma
- ☒ Cancer
- ☒ Diabetes
- ☐ Easy Bleeding
- ☐ Gout
- ☒ Heart Trouble
- ☒ High Blood Fats
- ☒ High Blood Pressure
- ☐ Jaundice
- ☐ No Known Family History
- ☒ Obesity
- ☐ Others
- ☐ Psychiatric Illness
- ☐ Stroke
- ☐ Tuberculosis

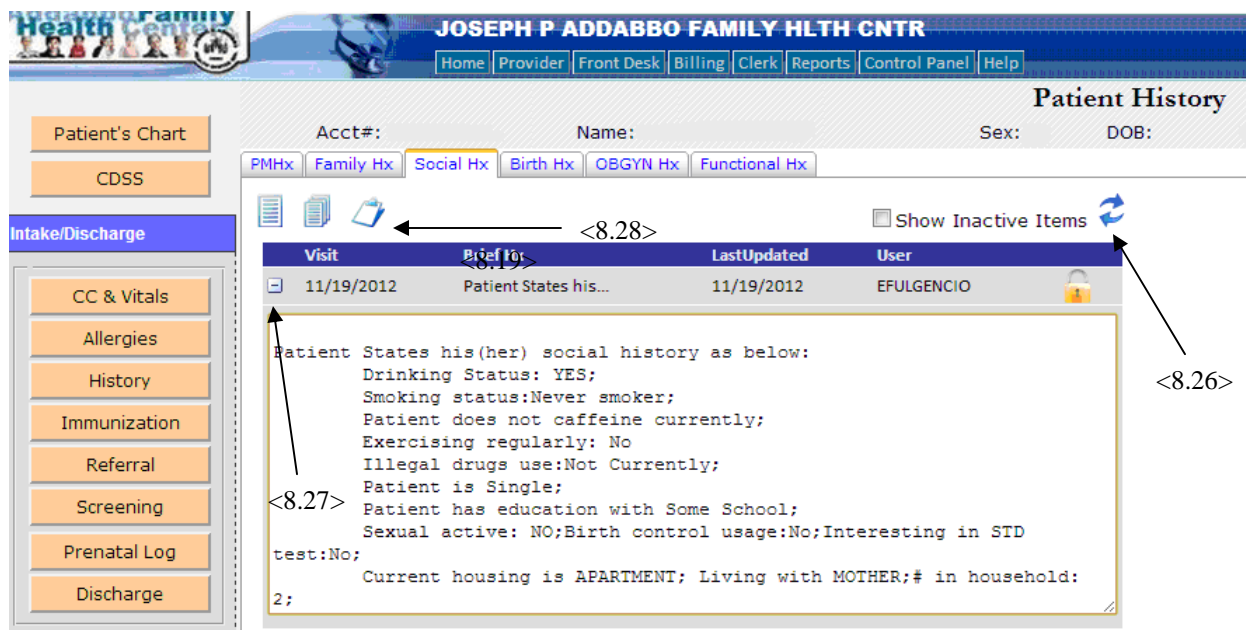
Comments:  <8.23>

**Add To Family History**

Figure 8.22

## 5.6 Social History:

To view inactive items under the history tab, check the “*Inactive Items*” check box and click on the refresh  button to refresh the list (<8.26>). To see more details about the patient’s history, click on the  button to view comments that the provider entered (<8.27>). Click on “*View Hx History*” icon to view the patient’s notes/history. To add new social information about the patient, click on the “*Create New Hx*”. (<8.28>).





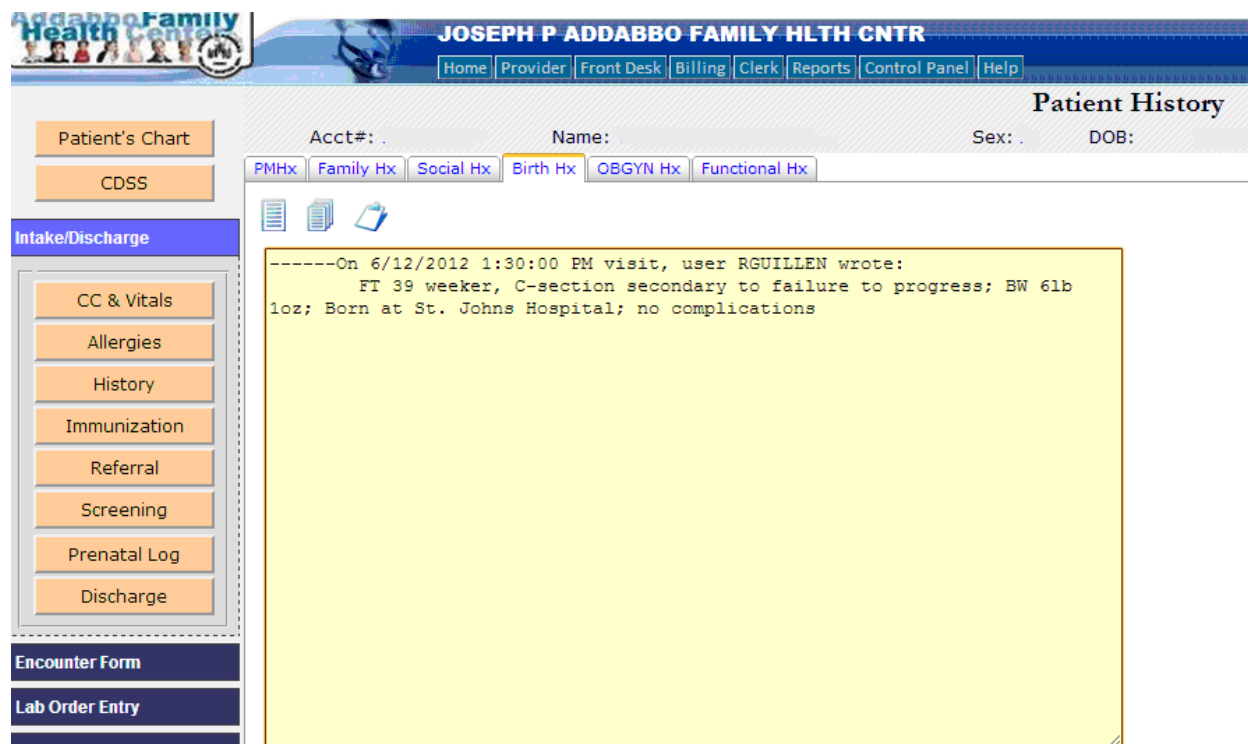
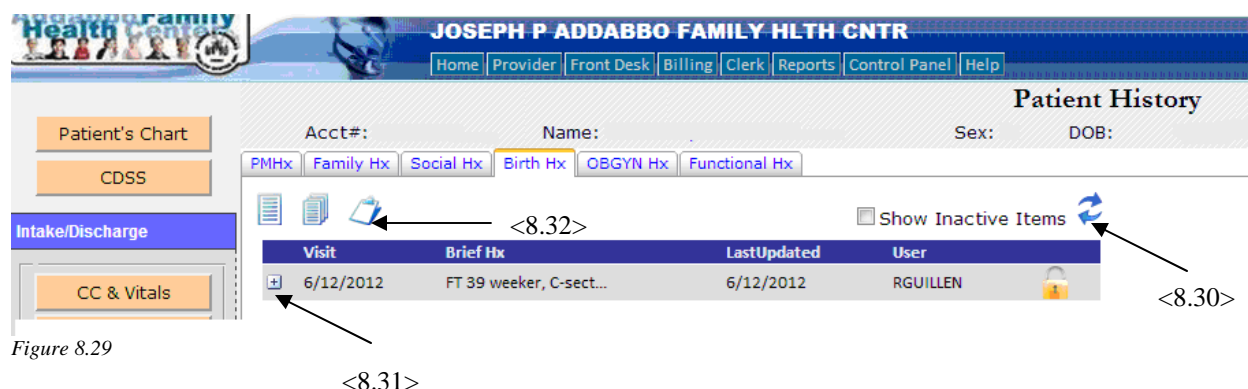
The screenshot displays the 'Patient History' section for 'JOSEPH P ADDABBO FAMILY HLTH CNTR'. The interface includes a sidebar with navigation options such as 'Patient's Chart', 'CDSS', and 'Intake/Discharge'. The main area shows the 'Social Hx' tab selected. A table lists visits, with the first entry dated 11/19/2012. A 'Show Inactive Items' checkbox is present. A large text box displays the patient's social history details, including drinking status, smoking status, and other personal information. Annotations with arrows point to specific UI elements: <8.28> points to the 'Create New Hx' button, <8.26> points to the refresh button, and <8.27> points to the plus button.

Figure 8.25



## 5.7 Birth History:

To view inactive items under the history tab, check the “*Inactive Items*” check box and click on the refresh  button to refresh the list (<8.30>). To see more details about the patient’s history, click on the  button to view comments that the provider entered (<8.31>). To view the patient’s history list, click on the “*View Hx List*”. A list of the patient’s birth history will appear. Click on “*View Hx Summary*” to view the summary of the patient’s history. (Figure 8.33)



Click on “*Create New Hx*” to create a new history summary for the patient. There is a text box available for free typing of the text. If the provider wishes to use “*SmartNotes Tools*”, click on the button and add the information regarding the birth. Select “*Generate SmartNotes*” to add the selected notes (<8.35>). If a previous history exists and the provider wishes to overwrite, select “*Overwrite*” and click on “*Generate SmartNotes*”. Once this is done, click on the “*Save*” button to save the notes to the system.

**JOSEPH P ADDABBO FAMILY HLTH CNTR**

Home Provider Front Desk Billing Clerk Reports Control Panel Help

**Patient History**

Acct#: Name: Sex: DOB:

PMHx Family Hx Social Hx **Birth Hx** OBGYN Hx Functional Hx

**Birth History:**

1. Birth Weight: 6 Birth Length: 11 Obstetrician:

2. Birth Date: 05/25/1991 Birth Place: Skeldon, Guyana

3. Prenatal Problems? ☒ No ☐ Yes  
(e.g. diabetes, high blood pressure)  
if yes, detail:

4. Labor/Delivery: ☒ Normal Vaginal Birth ☐ C-section ☐ Other Problems  
if others, detail:

5. Newborn Problems? ☒ No ☐ Yes  
(e.g. premature, jaundice, infection)  
if yes, detail:

6. Hearing Screen: ☒ Pass ☐ Fail  
if fail, detail:

7. Newborn Screen: Newborn Screening ID:   
☒ Normal ☐ Abnormal  
if abnormal, detail:





☐ Overwrite ☒ Append

**Generate Smart Notes** Cancel

Figure 8.34

&lt;8.35&gt;

## 5.8 OBGYN History:

On the OBGYN History tab, the patient's history list will appear. If the user would like to make any changes to the notes already on the list, simply click on the  icon to edit the note. A page as displayed in figure (Figure 8.36) will appear. The user can either choose to use the Smart Notes Tool to edit the note, or manually type in the notes in the available box provided for free typing of the text (<8.39>). To delete the note, click on the  symbol. Or if the user would like to lock the note, simply click on the  symbol. To view inactive items, check the "Show Inactive Item" box and then click on the "Refresh"  icon to refresh the list. (<8.37>)

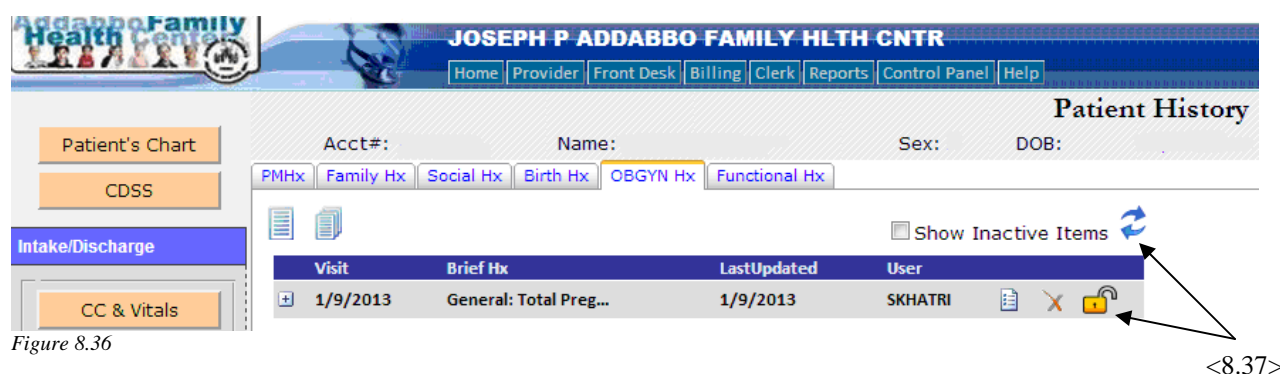


Figure 8.36

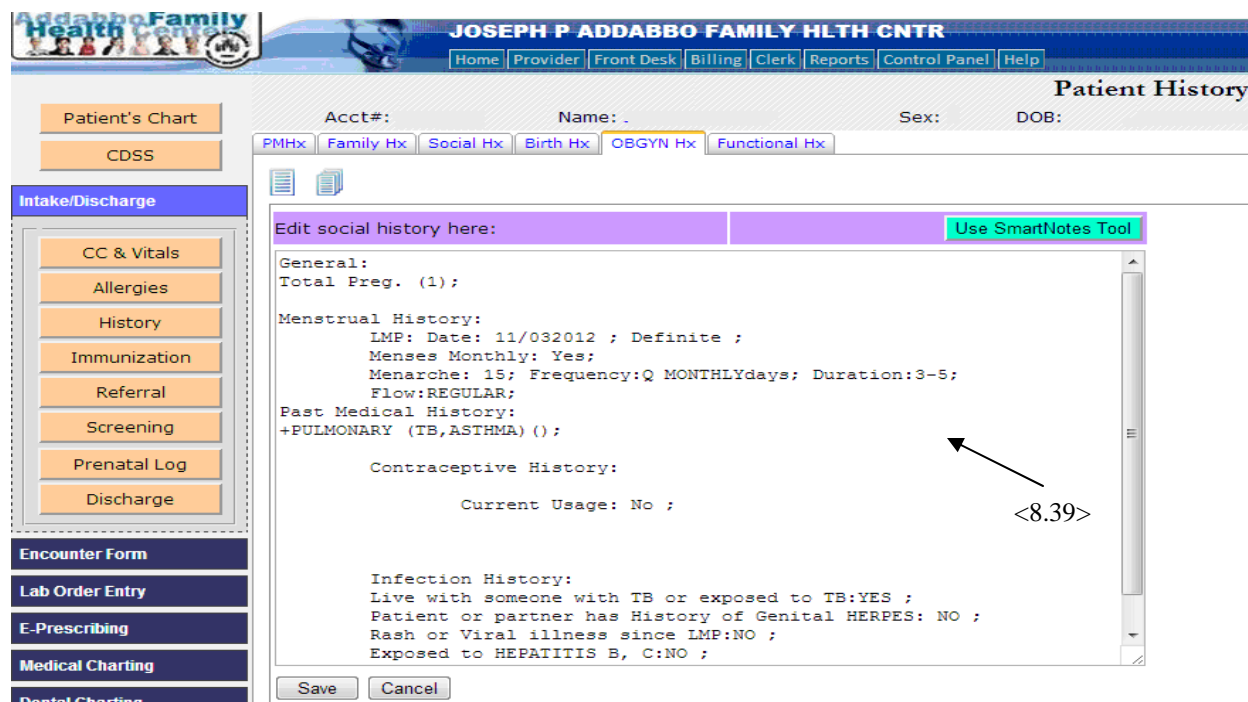


Figure 8.38

**General:**

TOTAL PREG	FULL TERM	PREMATURE	AB. INDUCED	AB. SPONTANEOUS	ECTOPICS	MULTIPLE BIRTHS	LIVING

**Menstrual History:**

LMP Date: 1/10/2013 ☐ Definite ☐ Approximate (Month Known) ☒ Unknown ☐ Normal Amount/Duration

PMP:  Menses Monthly: ☐ Yes ☐ No Final:

Menarche:  Frequency: Q  days Duration:

Flow:  Pain:  Intermenstrual Bleeding:

hCG+:  On BCP AT CONCEPT ☐ Yes ☐ No

Comments:

**Past Pregnancies (Last Six):**

DATE	GA WEEKS	LENGTH OF LABOR	BIRTH WEIGHT	SEX	TYPE DELIVERY	ANES	PLACE OF DELIVERY	PRETERM LABOR	COMMENTS/COMPLICATIONS
1/1/2013				M					

**Past Medical History:**

	Neg/Pos	Detail For Positive		Neg/Pos	Detail For Positive
1. DIABETES	-		16. D (Rh) SENSITIZED	-	
2. HYPERTENSION	-		17. PULMONARY (TB, ASTHMA)	-	
3. HEART DISEASE	-		18. ALLERGIES (DRUGS)	-	
4. AUTOIMMUNE DISORDER	-		19. BREAST	-	
5. KIDNEY DISEASE/UTI	-		20. GYN SURGERY	-	
6. NEUROLOGIC/EPILEPSY	-		21. OPERATION/HOSPITALIZATIONS	-	
7. PSYCHIATRIC	-		22. ANESTHETIC COMPLICATIONS	-	
8. HEPATITIS/LIVER DISEASE	-		23. HISTORY OF ABNORMAL PAP	-	
9. VARICOSES/PHLEBITIS	-		24. UTERINE ANOMALY/DES	-	

Figure 8.40

To view the patient's History Summary, click on the "View Hx History" icon.

Here you will see a summary of the patient's history. (Figure 8.41)

**JOSEPH P ADDABBO FAMILY HLTH CNTR**

Home | Provider | Front Desk | Billing | Clerk | Reports | Control Panel | Help

**Patient History**

Acct#: Name: Sex: DOB:

PMHx | Family Hx | Social Hx | Birth Hx | OBGYN Hx | Functional Hx

-----On 1/9/2013 9:15:00 AM visit, user SKHATRI wrote:

**General:**  
Total Preg. (1);

**Menstrual History:**  
LMP: Date: 11/03/2012 ; Definite ;  
Menses Monthly: Yes;  
Menarche: 15; Frequency: Q MONTHLY days; Duration: 3-5;  
Flow: REGULAR;





**Past Medical History:**  
+PULMONARY (TB, ASTHMA) ();

**Contraceptive History:**  
Current Usage: No ;

**Infection History:**  
Live with someone with TB or exposed to TB: YES ;  
Patient or partner has History of Genital HERPES: NO ;  
Rash or Viral illness since LMP: NO ;

Figure 8.41

## 5.9 Functional History:

On the Functional History tab, the patient's history list will appear. If the user would like to make any changes to the notes already on the list, simply click on the  icon to edit the note. The user can either choose to use the Smart Notes Tool to edit the note, or manually type in the notes in the available box provided for free typing of the text. To delete the note, click on the  symbol, or if the user would like to lock the note, simply click on the  symbol. To view inactive items, check the “*Show Inactive Item*” box and then click on the “Refresh”  icon to refresh the list.

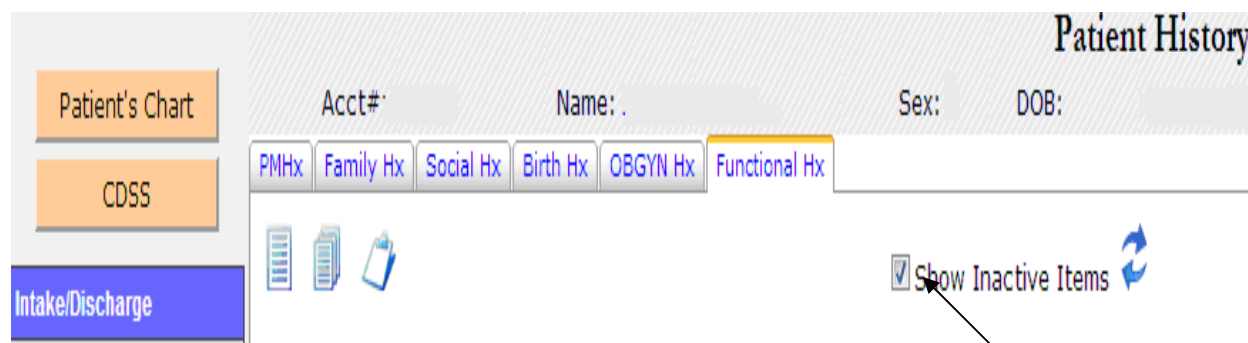


Figure 8.42

<8.43>

Click on “*Create New Hx*” to create a new history summary for the patient. There is a text box available for free typing of the text (<8.45>). If the provider wishes to use “*SmartNotes Tools*”, click on the button and add the appropriate information needed. Select “*Generate SmartNotes*” to add the selected notes. If a previous history exists and the provider wishes to overwrite, select “*Overwrite*” and click on “*Generate SmartNotes*” (<8.47>). Once this is done, click on the “*Save*” button to save the notes to the system.

JOSEPH P ADDABBO FAMILY HLTH CNTR

Home Provider Front Desk Billing Clerk Reports Control Panel Help

Patient History

Acct#: Name: Sex: DOB:

PMHx Family Hx Social Hx Birth Hx OBGYN Hx Functional Hx

Intake/Discharge

CC & Vitals

Allergies

History

Immunization

Referral

Screening

Prenatal Log

Discharge

Encounter Form

Lab Order Entry

E-Prescribing

Medical Charting

Dental Charting

Edit social history here:

Testing\_

Use SmartNotes Tool

<8.45>

Save Cancel

Figure 8.44

JOSEPH P ADDABBO FAMILY HLTH CNTR

Home Provider Front Desk Billing Clerk Reports Control Panel Help

Patient History

Acct#: Name: Sex: DOB:

PMHx Family Hx Social Hx Birth Hx OBGYN Hx Functional Hx

Intake/Discharge

CC & Vitals

Allergies

History

Immunization

Referral

Screening

Encounter Form

Lab Order Entry

E-Prescribing

Medical Charting

Dental Charting

Functional History:

☒ Full Independence

☐ Full dependence in locomotion

☐ Modified independence

☐ Full dependence in social cognition

☐ Distant supervision

☐ Full dependence in communication

☐ Close supervision

☒ Assistive device-wheelchair

☐ Needs assistance

☐ Assistive device-walker

☐ Full dependence in self-care

☐ Assistive device-crutches

☐ Full dependence in sphincter control

☐ Assistive device-cane

☐ Full dependence in mobility

☐ Overwrite ☒ Append **Generate SmartNotes** Cancel

<8.47>

Figure 8.46

## 5.10 Immunization:

Described in the previous section. Click here to view.

## 5.11 Referral:

Described in the previous section. Click here to view

## 6.0 Screening and Intervention:

In order to add the Screening and Intervention, select the type of screening from the drop down and click on the “Create new” button (<9.2>). There is a text box available for free typing of the text. If the provider wishes to use “SmartNotes Tool”, click on the button and add information regarding the social history. Select “Generate SmartNotes” to add the selected notes (<9.3>). If a previous history already exists and the provider wishes to overwrite, select “Overwrite” and then click on “Generate SmartNotes” (<9.5>). Once this is done click on the “Save” button to save the notes to the system. If the patient has screening notes from previous visits, it can be found on the left side of the page. The provider can click on the lock symbol to lock the history notes from further changes.

The screenshot shows the 'Screening and Intervention' section of the EHR. On the left, a sidebar menu lists various patient charting options, with 'Screening' selected. The main window displays a form for 'PPD Screening'. At the top, there are fields for 'Acct#:', 'Name:', 'Sex:', 'DOB:', 'Age:', 'MRN:', and 'Bal\_Due:'. Below these, a 'Select Screening Type:' dropdown is set to 'PPD Screening'. A 'Past Screenings:' table shows a previous screening on 8/1/2012. The main text area contains a detailed note about the PPD screening performed on 8/1/2012, including the patient's history, test results, and interpretation. A 'Create New' button is labeled with the reference <9.2>. A 'View SmartNotes Tool' button is also present. The bottom of the form has buttons for 'Create New', 'Edit', 'Save', and 'Reset'.

Figure 9.1

This screenshot shows a more detailed view of the 'PPD Screening' form. It includes sections for 'Prior Test', 'TB Test', and 'Interpretation'. The 'TB Test' section has fields for 'Test Date', 'Placement Site', 'TB lot #', and 'Expiration date'. The 'Interpretation' section includes 'Date Interpreted', 'Reading Site', 'Incubation (mm)', 'Chest X-ray Date', and 'Chest X-ray Reading'. The 'Outcome' section has checkboxes for 'LTBI treatment prescribed', 'No Treatment needed', 'No treatment indicated', 'Treatment deferred', 'Patient being evaluated as a TB suspect', 'Patient refused treatment', 'Treatment not advised due to high risk of hepatitis', and 'Previously treated for TB or LTBI'. A 'Generate Smart Notes' button is labeled with the reference <9.3>. Other buttons at the bottom include 'Overwrite', 'Append', and 'Cancel'.

Figure 9.4



## 7.0 Pre-Natal Log:

This page displays the patient's pregnancy information. Click on "Add New" and add the appropriate information and then click on "Save" to save the information to the system (<10.2>).

The screenshot shows the 'Prenatal Care Log' form for a patient at the Joseph P Addabbo Family Health Center. The form is divided into several sections. On the left is a navigation menu with options like 'Patient's Chart', 'CDSS', 'Intake/Discharge', and various clinical categories. The main form area contains fields for patient information (Acct#, Name, Sex, DOB) and pregnancy details. The pregnancy details section includes fields for 1st Visit, Trimester, Current Status, EDC Date, HIV PreTest Date, HIV Test Result, Last Visit, HIV PostTest Date, 1st Visit Provider, Delivery Provider, Delivery Date, Birth Weight, New Born Visit Date, and Post Partum Visit Date. On the right side of the form are three buttons: 'Save', 'Reset', and 'Add New'. An arrow points from the text '<10.2>' to the 'Add New' button.

Acct#: .		Name:		Sex:	DOB:
1st Visit:	Trimester:	Current Status:			
1/3/2012	3	In Care			
EDC Date:	HIV_PreTest_Date:	HIV Test Result:			
	1/24/2012	Negative			
Last Visit:	HIV_PostTest_Date:				
7/26/2012	1/25/2012				
1st Visit Provider:					
GYN		CARLENE			
Delivery Provider:					
GYN		CARLENE			
Delivery Date: 9/21/2012					
Birth Weight:					
New Born Visit Date: 9/24/2012					
Post Partum Visit Date:					

Figure 10.1



## 8.0 Encounter Form:

This is the main form for the providers. Please select the department if present in the left navigation bar (<11.2>).

The providers are expected to fill the form with procedure/diagnosis code and close the encounter for each patient they see. There are two tabs in the encounter form. The Procedure and Diagnosis tab, these tabs can be found at the top of the page (<11.3>).

If any Immunization Vaccines/Injection Medication/Injection Procedure/Vaccine Administration or Other Procedure is done, please select from the list of that section (<11.4>). If there is a vaccine/lab/injection or other procedures done to the patient are missing from the list it can be searched in the other procedures box on the right side of the page (<11.5>).

The search box can search either by the CPT code or by keyword. If a keyword is used please use 3 letters minimum and then click on “Search”. The result of the search appears in the dropdown. Please select the procedure you are looking for (<11.6>).

<11.3>

<11.2>

<11.4>

<11.5>

<11.6>

Figure 11.1

## 8.1 Procedure:

If you would like to overwrite the billing rule please select “Yes” for “*Overwrite Billing Rule*” (<11.8>).

For an office visit please check the duration of time spent with the patient in the visit.  
For preventive visit please select the “*Preventive Visit*” tab and then the age of the patient (<11.9>).

The screenshot shows a software interface with two tabs: "Procedure" and "Diagnosis". Below these is a dialog box titled "Overwrite Billing Rule?". At the top right of the dialog, there are two radio buttons labeled "YES" and "NO", with the "YES" button selected. An arrow labeled "<11.8>" points to the "YES" button. Below the title bar, there are two sub-tabs: "Office Visit" and "Preventive Visit". The "Office Visit" tab is active, showing a list of checkboxes for age groups. The first checkbox, "18-39 Yrs(New)", is checked. An arrow labeled "<11.9>" points to this checkbox. Other checkboxes include "40-64 Yrs(New)", ">=65 Yrs(New)", "18-39 Yrs(Est)", "40-64 Yrs(Est)", and ">=65 Yrs(Est)".

Figure 11.7

## 8.2 Quick Diag Code:

The providers are provided with the most common diagnosis code for quick adding into the system. If the patient is diagnosed with a condition not in the list, we can add by going to diagnosis tab.

## 8.3 Diagnosis:

There is a list of the most common diagnosis available for the provider's convenience. If a diagnosis code is not available in the list, the provider can search either by the ICD-9 code or by keyword. The result appears in the dropdown below. Make a selection to add to the list of diagnosis. (<11.11>)

If the provider still cannot find the diagnosis they are looking for from the dropdown list, there is a provision to search from "Google" on the right side of the page. Enter the code/ diagnosis and click "Google search". This opens a new tab showing the result in description regarding the diagnosis. (<11.12>)

The provider is expected to copy the right diagnosis code and add it to the search box in the diagnosis by code in order to enter it into the encounter form. The description for a code available in the EHR system could be different from the description the provider is looking for. So the Google search gives the capability to search for the right code based on various descriptions available.

The screenshot displays the 'Adult Medicine Encounter Form' in the CyberMed EHR system. The form includes fields for Date, Acct#, Name, Sex, Age, and File#, along with a 'Submit' button. A search bar is present with options to search 'By Keyword' or 'By Code'. A dropdown menu is open, showing a list of medical conditions with their corresponding ICD-9 codes. Some conditions are highlighted in yellow, including 'Diabetes II Uncontrolled...250.02', 'Hyperthyroidism...242.90', 'IMPAIRED FASTING GLUCOSE ...790.21', and 'Upper Respiratory Infection...465.9'. A 'Google Search' button is located on the right side of the form. An arrow points from the text '<11.12>' to the 'Google Search' button.

Figure 11.10

Once the procedure code/diagnosis codes are selected, please click on “*Submit*” to save in the system. On save, a summary page appears of the diagnosis and procedures. Please select the primary diagnosis of the visit. (Figure 11.13)

If the patient is being referred from outside, select “*The Visit Is In Coming Transition of Care*”. If the patient is referred to outside select “*The Visit Is Out Going Transition of Care*” (<11.14>)

Once all the selections are made, please select “*Confirm*” to submit.

A message appears showing “*Update Successfully*”. The provider can provide the patients with the education materials regarding their diagnosis by clicking on the handouts button.

There is an availability to check the “*Rx Reconciliation*” by clicking on the button. (<11.15>)

**Encounter Submission**

< PT Summary      Date:      Acct#:      Name:      Sex:      Age:      File#:

**Summary:**

Line	Procedure	Units	Description	Provider	Diag1	Diag2	Diag3	Diag4	
1	99213	1	Office/outpatient visit, est, mod	101	V76.10	V76.2			<a href="#">Edit</a>
2	99385	1	Preventive checkup, new, 18-39 yrs	101	V76.10	V76.2			<a href="#">Edit</a>
3	90632	1	HEP A	101	V76.10	V76.2			<a href="#">Edit</a>
4	90746	1	HEP B (ADULTS)	101	V76.10	V76.2			<a href="#">Edit</a>
5	90715	1	TDAP	101	V76.10	V76.2			<a href="#">Edit</a>
6	90736	1	ZOSTER (SHINGLES) VACCINE	101	V76.10	V76.2			<a href="#">Edit</a>
7	J1815	1	Insulin (5 units)	101	V76.10	V76.2			<a href="#">Edit</a>
8	86480	1	PPD reading	101	V76.10	V76.2			<a href="#">Edit</a>
9	88155	1	PAP SMEAR	101	V76.10	V76.2			<a href="#">Edit</a>
10	87070	1	BACTERIAL THROAT CULTURE	101	V76.10	V76.2			<a href="#">Edit</a>
11	90472	1	2ND IMMUNIZATION ADMINISTERED	101	V76.10	V76.2			<a href="#">Edit</a>
12	90473	1	COMBO IMMUNIZATION ADMINISTERED	101	V76.10	V76.2			<a href="#">Edit</a>

**Select Primary:** ☐ BREAST SCREENING, UNSPEC ☒ SCREENING FOR MALIGNANT NEOPLASMS OF THE CERVIX

**Select Referral:**

**Visit Type:** ☒ The visit is in coming transition of care ☐ The visit is out going transition of care

**Thank You. Update Successfully**  
Patient Education Resources for Dx Code

Ln	Dx Code	Description	
1	V76.2	SCREENING FOR MALIGNANT NEOPLASMS OF THE CERVIX	<a href="#">Handouts</a>
2	V76.10	BREAST SCREENING, UNSPEC	<a href="#">Handouts</a>

[Rx Reconciliation](#)    [Provide Record Summary](#)

Figure 11.13

## 9.0 Lab Order Entry:

### 9.1 Order Lab

This is the place to order labs. Click on the dropdown list to select a “*Template*”, this can either be “*Regular, Pre-Natal, Pap smear, RW, Drug Screen or Urology*” or “*User own list*” (<12.2>).

Select the labs needed to be ordered (<12.3>). The provider can also search for lab orders either by keyword or by code. The result will appear in the dropdown next to the “*By Code*” button. Select the appropriate lab and it will be highlighted in your list. Once all the labs are entered enter the pin which is typically followed by the provider number and click on submit (<12.4>)

A review page appears which a provision to add notes to order the lab and click on “*Confirm*” to order the labs. A page confirming successful ordering of the lab appears which the provider can print and give it to the patient.

The following image shows how your template of lab order appears every time you click on “*Order lab*” by default. If you would like to use regular template select it from the drop down of templates.

Figure 12.1

### 9.1.1 Make My Own List:

To make your own list, click on “*Make My Own List*” (<12.2>). Please select the lab vendor from the dropdown list. In order to search for the labs to add to your list you can use “*Quick filter*” and enter either the test code or the test name and filter for results or if this is not successful for the desired result you can manually search the lab from the list page by page (<12.6>). Click the lab test names and click on “*Add to My List*” (<12.7>).

In order to remove lab tests from your list select the test names on the right side of the page (your list) and click on “*Remove from MyList*” (<12.8>).

<12.6>

<12.7>

<12.8>

Figure 12.5

## 9.2 Order Imaging:

This is the place to order different types of imaging. Select the template from the drop down of the types of imaging (<12.10>). Select the lab name and other information with respect to the test and enter the pin code to submit (<12.11>, <12.12>). The success page appears which can be printed out to be given to the patient.

Imaging Lab Order

Acct#: Name: Sex: DOB: Age: MRN: Bal\_Due: \$74.55

Select Template: MRI

TestName	LT	Note
CT SCAN		
CERVICAL SONOGRAPHY		
MAMMOGRAPHY		
THORACIC X-RAY		
DXA SCAN		
LUMBER SPINE		
BRAIN	<input checked="" type="checkbox"/>	
PITUITARY		
IACS		
ORBITS		
SINUSES	<input checked="" type="checkbox"/>	
TMJ		
BRACHIAL PLEXUS		
ABDOMEN	<input checked="" type="checkbox"/>	
PELVIS		
SHOULDER		
ELBOW	<input checked="" type="checkbox"/>	
WRIST		
HAND	<input checked="" type="checkbox"/>	
HIP	<input checked="" type="checkbox"/>	
KNEE	<input checked="" type="checkbox"/>	
ANKLE		
FOOT		
OTHER		

pin code: Submit

Figure 12.9

## 10.0 MEDICAL CHARTING:

### 10.1 Problem List:

*Please refer to page 18 for this tutorial.*

### 10.2 History of Present Illness (HPI)

This page allows the provider to add in detail the history of present illness. The provider is provided with a text box to freely type his/her notes into the system and save it (<13.2>).

JOSEPH P ADDABBO FAMILY HLTH CNTR

Welcome, CPETERS Logout

Home Provider Front Desk Billing Clerk Reports Control Panel

Pharm: 7 Fax: 6 Pending: 982

Acct#: Name: Sex: DOB: Age: MRN: Bal\_Due: \$74.55

History of Present Illness

HPI List: Create New

Select template: REGULAR Use SmartNotes Tool

Visit	User	
View 3/9/2012	dmedelea	🔒
View 2/16/2012	daltman	🔒

Context:

F/u visit; seen by ent for f/u om. Complaints of snoring at night and congestion most of the time. Developed an itchy rash over R ear.

<13.2>

<13.3>

SAVE RESET

Figure 13.1



### 10.2.1 Use SmartNotes Tool:

This is a tool generated to help the providers to enter the desired information with minimum typing. Click on the button “*Use Smart Notes Tool*” to go to the page (<13.3>).

The patient’s age and sex information is pre-generated (<13.5>). Select various categories like complaint, location quality, etc. Provided are the most common items in each category, select various items. If any additional notes are to be added in any category please add it to the textbox available in each category (<13.6>).

You can overwrite the existing notes or append/add to the existing notes by selecting the radio button at the end of the page and click on “*Generate Smart notes*”. This will add your selections to the note’s text box in a format. The provider can add/make additional changes to the text if he wishes (<13.7>).

**JOSEPH P ADDABBO FAMILY HLTH CNTR**

Home Provider Front Desk Billing Clerk Reports Control Panel

**History of Present Illness**

Acct#: . Name: Sex: DOB:

< Back Reset All Selections <13.5>

Patient is 14 years old female.

**Complaint**

<input checked="" type="checkbox"/> Abdominal Complaints	<input type="checkbox"/> Eye Complaints	<input type="checkbox"/> Lower Extremity	<input type="checkbox"/> Physical Exam - Male
<input checked="" type="checkbox"/> ACNE	<input type="checkbox"/> First Visit	<input checked="" type="checkbox"/> Neck & Back Pain	<input type="checkbox"/> Psychological
<input checked="" type="checkbox"/> ADD Evaluation	<input type="checkbox"/> Geriatrics	<input type="checkbox"/> Obesity	<input checked="" type="checkbox"/> Skin Rash - Lesion
<input checked="" type="checkbox"/> ADD Follow up	<input type="checkbox"/> Gynecological Problems	<input checked="" type="checkbox"/> Pain Management	<input checked="" type="checkbox"/> Upper Extremity
<input type="checkbox"/> Anorectal Problems	<input type="checkbox"/> Headache	<input checked="" type="checkbox"/> Physical Exam - Adolescent	<input type="checkbox"/> Upper Respiratory
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hyperten/Hyperlip	<input type="checkbox"/> Physical Exam - Child	<input type="checkbox"/> Urinary Tract Infection
<input type="checkbox"/> Chest Pain	<input checked="" type="checkbox"/> Ingrown Toenail	<input type="checkbox"/> Physical Exam - Female	<input type="checkbox"/> Urogenital - Male
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Laceration	<input type="checkbox"/> Physical Exam - Infant	

Location

Quality

Severity

Duration

Onset

Context

Modifying Factors

Symptoms


☐ Overwrite ☒ Append **Generate Smart Notes**

<13.6>

<13.7>

Figure 13.4

## 10.2.2 Make Your Own Template:

In order to make your own History of Present Illness template click on the  symbol (Figure 13.1). Select the group of category and select the available items/phrase from the list and click on “Add to My List” (<13.9>, <13.10>). If desired to add an item that is not available in the list, there is a text box saying “Or Enter New Item for This Group:” Type the new item and click on “Add” to add the item to the list (<13.11>).

This template can be composed at one time and will be available for the patient’s History of Present Illness. Any changes/add/removal of items reflects there-on-ward. In order to remove an item from your list select the item and click on “Remove from My List” (<13.12>).

On going back to History of Present Illness, the provider would find the template for Smart Notes default to the user template. In order to view regular template please select regular in template.

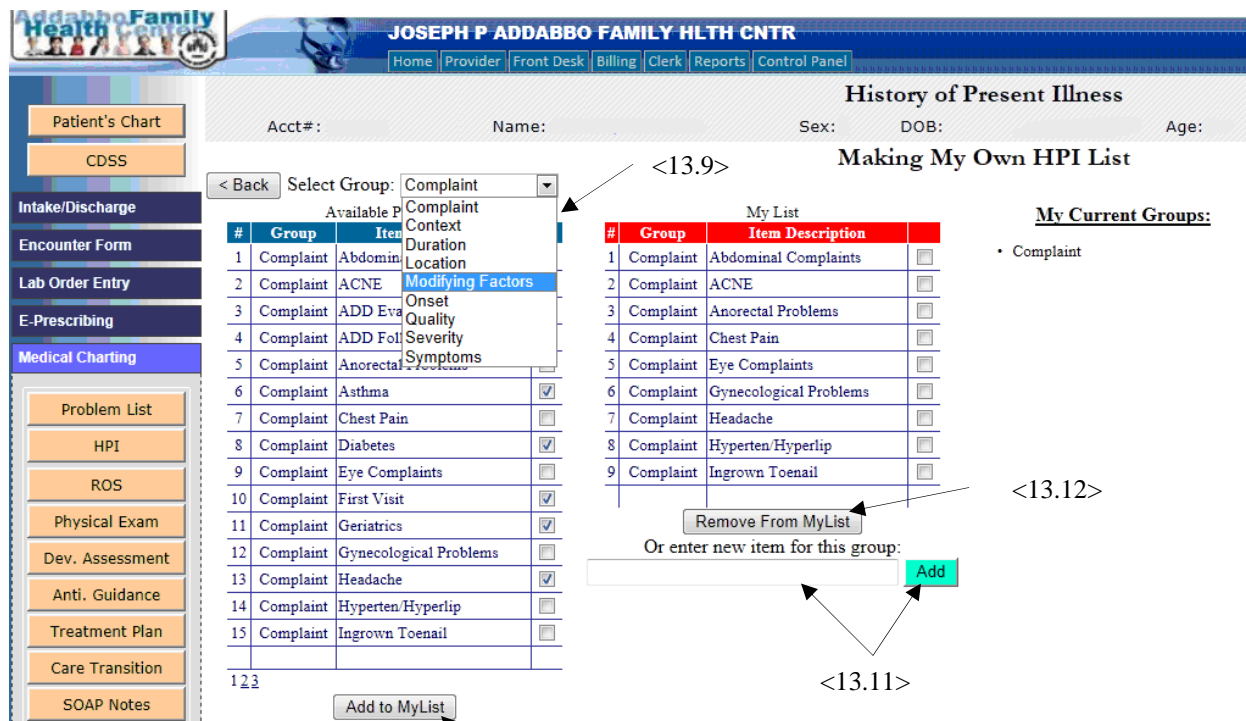


Figure 13.8

## 11.0 REVIEW OF SYSTEM:

This page allows the provider to add summary of a patient's main and general body system for basic functioning purposes. The provider is provided with a text box to freely type his/her notes into the system and save it (<14.2>). The provider can also use the "SmartNotes Tool" to help generate the note. (<14.3>)

The screenshot displays the 'Review of System' interface in the CyberMed EHR. The top navigation bar includes links for Home, Provider, Front Desk, Billing, Clerk, Reports, and Control Panel. The main header shows 'Pharm: 7, Fax: 6, Pending: 982'. The left sidebar contains a 'Patient's Chart' section with buttons for CDSS, Take/Discharge, Counter Form, Order Entry, Prescribing, Medical Charting, Problem List, HPI, ROS, Physical Exam, Dev. Assessment, Anti. Guidance, and Treatment Plan. The main content area is titled 'Review of System' and includes fields for Acct #, Name, Sex, DOB, Age, MRN, and Bal Due: \$0.00. Below these is a 'ROS List' table with columns 'Visit' and 'User', showing a row for '8/23/2012' by 'CPETERS'. A 'Summary' section contains a text box with patient findings, and a 'SmartNotes Tool' button. Arrows point to the text box (<14.2>) and the SmartNotes Tool (<14.3>). At the bottom are 'SAVE' and 'RESET' buttons.

Visit	User
8/23/2012	CPETERS

**Summary:**

Pertinent findings for this patient noted:

- GENERAL: Appetite Loss; Fatigue; Always tired; Weight Loss
- ALLERGY: Persistent Infections
- BREASTS: Gynecomastia
- CARDIOVASCULAR: Claudications
- ENDOCRINE: Diabetes
- EYES: Diplopia
- GASTRO: Abdominal Bloating
- GYN: Last Period; Period Duration
- NEURO: Hyperpathia; Sensation of Room Spinning
- PSYCH: Anxiety; Delusions; Depression; Mental Problems
- RESPIRATORY: Chest Discomfort
- SKIN: Cancer

Figure 14.1

## 11.1 Use SmartNotes Tool:

This is a tool generated to help the providers to enter the desired information with minimum typing. Click on the “*Use Smart notes tool*” button to go to the page (<14.3>). Select various categories like general, allergy, breast, etc. Provided are the most common items in each category, select various items. If any additional notes are to be added in any category please add it to the textbox available in each category (<14.5>).

You can overwrite the existing notes or append/add to the existing notes by selecting the radio button at the end of the page and click on “*Generate Smart Notes*”. This will add your selections to the note’s text box in a format. The provider can add/make additional changes to the text if he wishes.

**Addabbo Family Health Center**

**JOSEPH P ADDABBO FAMILY HLTH CNTR**

Home Provider Front Desk Billing Clerk Reports Control Panel

**Review of System**

Acct#: Name: Sex: DOB:

< Back Reset All Selections

**GENERAL**

☒ Apptite Loss ☐ Feeling of Sick ☐ Sleeping problems ☐ Weight gain  
☐ Chills ☐ Fevers ☐ Sweats ☒ Weight Loss  
☒ Fatigue; Always tired

**ALLERGY**

**BREASTS**

**CARDIOVASCULAR**

**ENDOCRINE**

**ENT**

**EYES**

**GASTRO** <14.5>

**GENITO**

**GYN**

**HEAD\_NECK**

**HEMATO**

**LYMPHATIC**

**MUSCULOSKELETAL**

**NEURO**

**PSYCH**

**RESPIRATORY**


**SKIN**

☐ Overwrite ☒ Append **Generate Smart Notes**

Figure 14.4

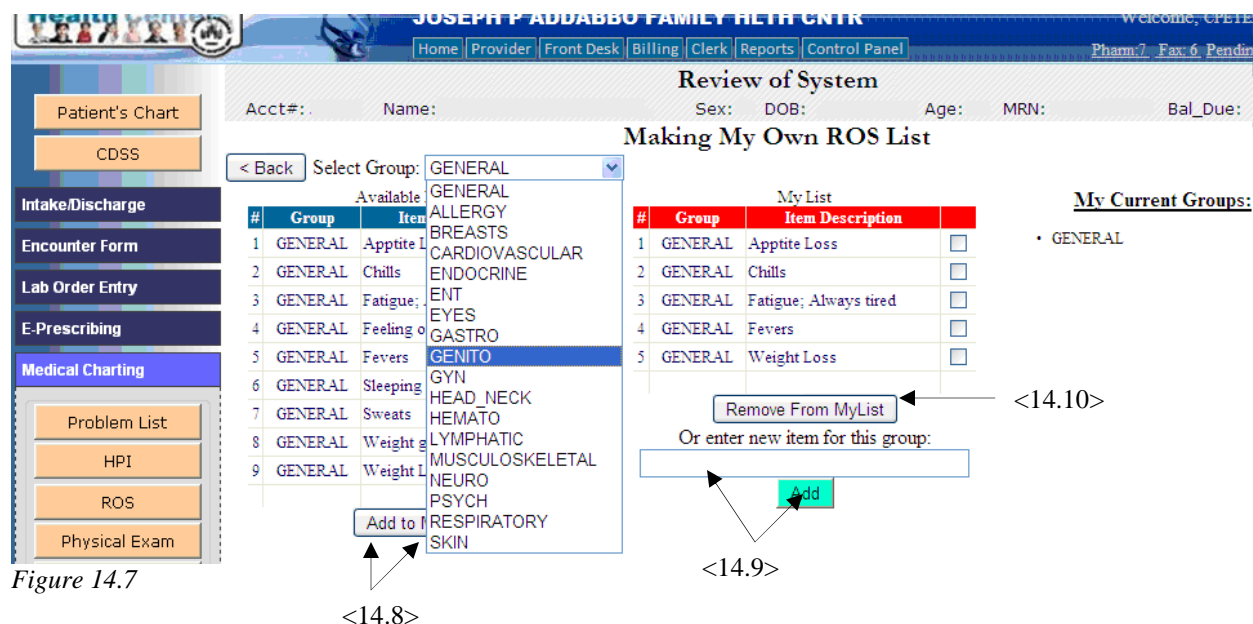
<14.6>

## 11.2 Make Your Own Template:

In order to make your own Review of System template click on the  symbol. Select the group of category and select the available items/phrase from the list and click on “Add to My List” (<14.8>). If desired to add an item that is not available in the list there is a text box saying “Or Enter New Item for This Group:” Type the new item and click on “Add” to add the item to the list (<14.9>).

This template can be composed at one time and will be available for the patient’s ROS. Any changes/add/removal of item reflects there-on-ward. In order to remove an item from your list select the item and click on “Remove from My List” (<14.10>).

On going back to ROS, the provider would find the template for Smart Notes default to the user template. In order to view regular templates please select “Regular” in template.



The screenshot displays the 'Review of System' interface for 'JOSEPH P ADDABBO FAMILY HEALTH CENTER'. The 'Making My Own ROS List' section is active, showing a list of available items for selection. The 'My List' table contains the following items:

#	Group	Item Description	
1	GENERAL	Apptite Loss	<input type="checkbox"/>
2	GENERAL	Chills	<input type="checkbox"/>
3	GENERAL	Fatigue; Always tired	<input type="checkbox"/>
4	GENERAL	Fevers	<input type="checkbox"/>
5	GENERAL	Weight Loss	<input type="checkbox"/>

The 'My Current Groups:' section shows 'GENERAL'.

Annotations in the image:

- <14.8> points to the 'Add to My List' button.
- <14.9> points to the 'Add' button in the 'Or enter new item for this group:' section.
- <14.10> points to the 'Remove From MyList' button.

Figure 14.7

## 12.0 Physical Exam:

The Physical Exam page is used to record providers' notes based on physical examination. The provider is provided with a text box to freely type his/her notes into the system and save it (<15.2>).

The screenshot displays the 'Physical Exam' page within the 'JOSEPH P. ADDABBO FAMILY HEALTH CENTER' EHR system. The interface includes a top navigation bar with links like 'Home', 'Provider', 'Front Desk', 'Billing', 'Clerk', 'Reports', and 'Control Panel'. A left sidebar contains various medical functions such as 'Patient's Chart', 'CDSS', 'Intake/Discharge', 'Encounter Form', 'Lab Order Entry', 'Prescribing', 'Medical Charting', 'Problem List', 'HPI', 'ROS', 'Physical Exam', 'Dev. Assessment', 'Anti. Guidance', and 'Treatment Plan'. The main content area is titled 'Physical Exam' and features a 'PE List' with a 'Create New' button. Below this, there are fields for 'Acct#:', 'Name:', 'Sex:', 'DOB:', 'Age:', 'MRN:', and 'Bal\_Due: (\$5.00)'. A 'Select template' dropdown is set to 'REGULAR', and a 'Use SmartNotes Tool' button is visible. A large text area labeled 'Context:' contains the text 'Testing patient's physical exam'. An arrow points from the label '<15.2>' to this text area. Another arrow points from the label '<15.3>' to the 'Use SmartNotes Tool' button. At the bottom of the page are 'SAVE' and 'RESET' buttons.

Figure 15.1

## 12.1 Use SmartNotes Tool:

This is a tool generated to help the providers to enter the desired information with minimum typing. Click on the button “*Use Smart Notes Tool*” to go to the page (<15.3>). Select various categories, for example: general appearance, abdomen, back, etc. Provided are the most common items in each category, select various items. If any additional notes are to be added in any category, please add it to the textbox available in each category (<15.5>).


You can overwrite the existing notes or append/add to the existing notes by selecting the radio button at the end of the page and click on “*Generate Smart Notes*” This will add your selections to the note’s text box in a format. The provider can add/make additional changes to the text if he wishes (<15.6>).

The screenshot shows the SmartNotes tool interface. The sidebar on the left contains navigation options: Patient's Chart, CDSS, Intake/Discharge, Encounter Form, Lab Order Entry, E-Prescribing, Medical Charting, Dental Charting, and MU Menu. The main area displays a form for 'JOSEPH P ADDABBO FAMILY HLTH' with fields for Acct# and Name. Below these are buttons for '< Back' and 'Reset All Selections'. The form is divided into sections: GENERAL APPEARANCE (with checkboxes for NAD and Well appearing), ABDOMEN, and a list of body parts (ANKLE, BACK, BREAST, Elbow, ENT, EYES, GASTRO, GENITALIA, Great Toe, HEAD, HEART, HEMATOLOGIC/LYMPHATIC, HIPS/EXTREMITIES, KNEE, LUNGS, MUSCULOSKELETAL, NECK, NEURO, RESPIRATORY, Shoulder, SKIN, SPINE, TEETH/MOUTH, Thumb, Wrist). A text box for additional notes is present next to the HEMATOLOGIC/LYMPHATIC category, labeled '<15.5>'. At the bottom, there are radio buttons for 'Overwrite' and 'Append', and a green button labeled 'Generate Smart Notes'.

Figure 15.4

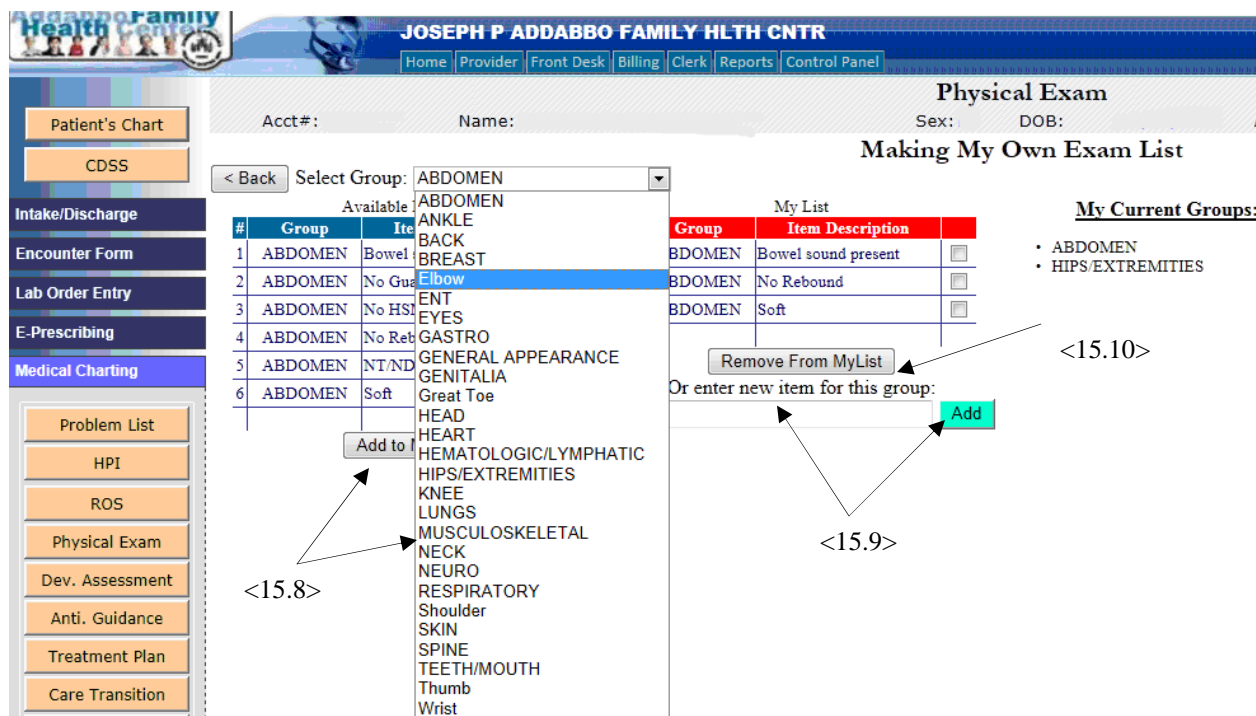
<15.6>

## 12.2 Make Your Own Template:

In order to make your own Physical Exam template click on the  symbol. Select the group of category and select the available items/phrase from the list and click on “Add to My List” (<15.8>). If desired to add an item that is not available in the list there is a text box saying “Or Enter New Item for This Group:” Type the new item and click on “Add” to add the item to the list (<15.9>).

This template can be composed at one time and will be available for the patient’s PE. Any changes/ add/ removal of item reflects there-on-ward. In order to remove an item from your list select the item and click on “Remove from My list” (<15.10>).

On going back to PE, The provider would find the template for smart notes default to the user template. In order to view regular templates please select “Regular” in template



**Physical Exam**

Acct#: Name: Sex: DOB:

**Making My Own Exam List**

< Back Select Group: ABDOMEN

#	Group	Item
1	ABDOMEN	Bowel
2	ABDOMEN	No Gut
3	ABDOMEN	No HSI
4	ABDOMEN	No Ref
5	ABDOMEN	NT/ND
6	ABDOMEN	Soft

Available: ABDOMEN, ANKLE, BACK, BREAST, BOWEL, No Gut, No HSI, No Ref, NT/ND, Soft, GASTRO, GENERAL APPEARANCE, GENITALIA, Great Toe, HEAD, HEART, HEMATOLOGIC/LYMPHATIC, HIPS/EXTREMITIES, KNEE, LUNGS, MUSCULOSKELETAL, NECK, NEURO, RESPIRATORY, Shoulder, SKIN, SPINE, TEETH/MOUTH, Thumb, Wrist

Add to

Group	Item Description
BDOMEN	Bowel sound present
BDOMEN	No Rebound
BDOMEN	Soft

Remove From MyList

Or enter new item for this group:

Add

My Current Groups:

- ABDOMEN
- HIPS/EXTREMITIES

Figure 15.7



## 13.0 Development Assessment:

This page is used to record provider's notes of development assessment of children. The provider is provided with a text box to freely type his/her notes into the system and save it (<16.2>).

The screenshot displays the 'Development Assessment' form within the CyberMed EHR system. The interface includes a top navigation bar with links like Home, Provider, Front Desk, Billing, Clerk, Reports, and Control Panel. A left sidebar contains various menu items such as Patient's Chart, CDSS, and Medical Charting. The main form area is titled 'Development Assessment' and contains fields for Acct#, Name, Sex, DOB, Age, MRN, and Bal\_Due. A 'Select template' dropdown is set to 'REGULAR', and a 'Use SmartNotes Tool' button is visible. The 'Context' section contains a text box with the placeholder text 'Testing patient's development assessment.' An arrow labeled '<16.2>' points to this text box. Another arrow labeled '<16.3>' points to the 'Use SmartNotes Tool' button. At the bottom of the form are 'SAVE' and 'RESET' buttons.

Figure 16.1

### 13.1 Use SmartNotes Tool:

This is a tool generated to help the providers to enter the desired information with minimum typing. Click on the button “*Use Smart Notes Tool*” to go to the page (<16.3>). Select various age groups from the drop down (<16.5>). Provided are the most common items, select various items. If any additional notes are to be added in any category please add it to the comments box available next to each item (<16.6>).

You can overwrite the existing notes or append/add to the existing notes by selecting the radio button at the end of the page and click on “*Generate Smart Notes*” This will add your selections to the note’s text box in a format. The provider can add/make additional changes to the text if he wishes. (<16.7>)

**JOSEPH P ADDABBO FAMILY HLTH CNTR**

Home Provider Front Desk Billing Clerk Reports Control Panel

**Development Assessment**

Acct#: Name: Sex: DOB:


< Back Select group: 15 months

Item Description	Assessment	Comments
Dada, Mama specific	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Testing patient's assessment
Feeds self	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Persistent rocking, handflapping or headbanging	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<16.6>
Plays pat-a-cake	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Testing assessment
Scribbles	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Walks alone well	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Reset All Yes		

☐ Overwrite ☒ Append **Generate Smart Notes**

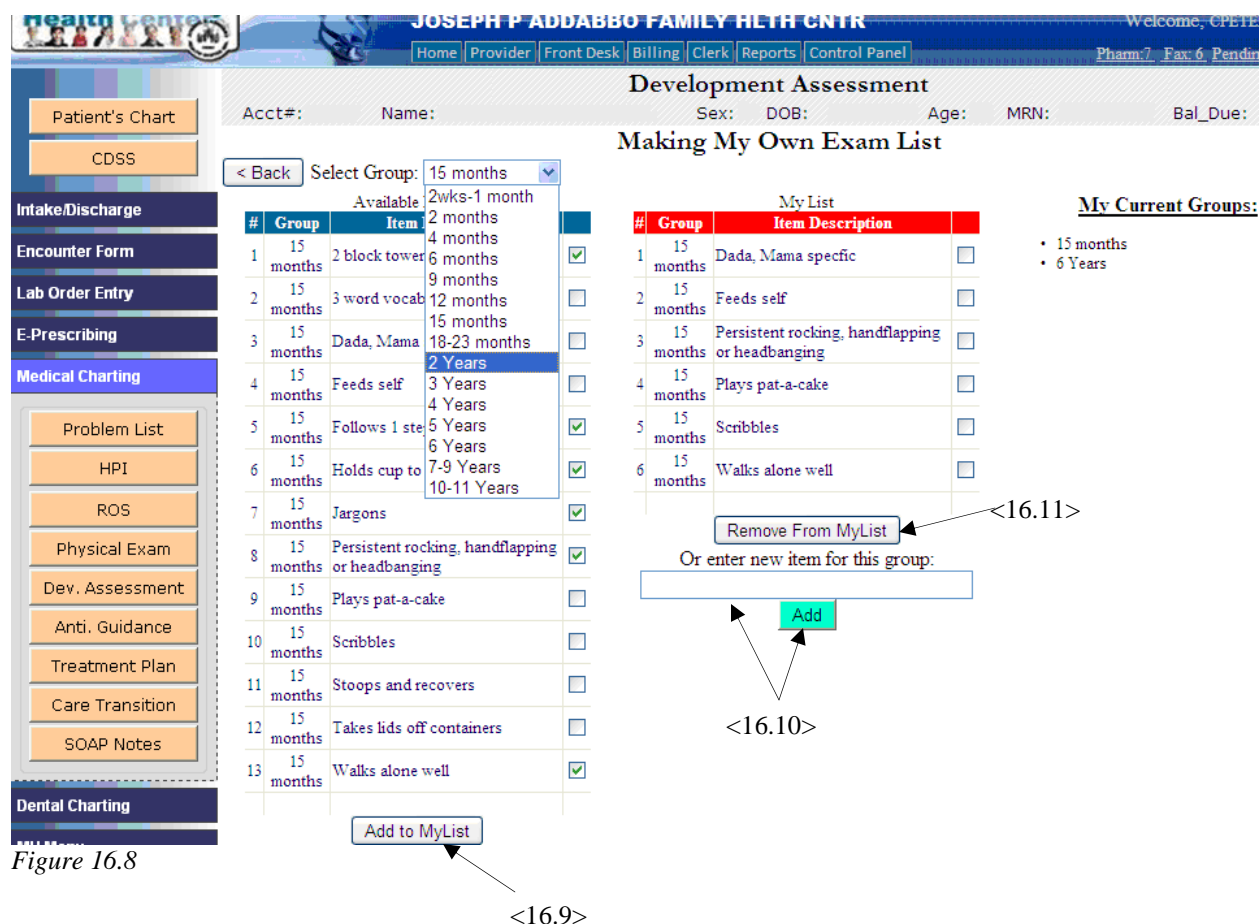
Figure 16.4

## 13.2 Make Your Own Template:

In order to make your own Development Assessment template click on the  symbol. Select the age group and select the available items from the list and click on “Add to My List” (<16.9>). If desired to add an item that is not available in the list there is a text box saying “Or Enter New Item For This Group:” Type the new item and click on “Add” to add the item to the list (<16.10>).

This template can be composed at one time and will be available for the patient’s Development Assessment. Any changes/ add/ removal of item reflects there-on-ward. In order to remove an item from your list select the item and click on “Remove from My list” (<16.11>).

On going back to Development Assessment, The provider would find the template for Smart notes default to the user template. In order to view regular template please select regular in “Template”



**Development Assessment**

Acct#: Name: Sex: DOB: Age: MRN: Bal\_Due:

**Making My Own Exam List**

Select Group: 15 months

#	Group	Item	Available
1	15 months	2 block tower	<input checked="" type="checkbox"/>
2	15 months	3 word vocab	<input type="checkbox"/>
3	15 months	Dada, Mama	<input type="checkbox"/>
4	15 months	Feeds self	<input type="checkbox"/>
5	15 months	Follows 1 step	<input checked="" type="checkbox"/>
6	15 months	Holds cup to	<input checked="" type="checkbox"/>
7	15 months	Jargons	<input checked="" type="checkbox"/>
8	15 months	Persistent rocking, handflapping or headbanging	<input checked="" type="checkbox"/>
9	15 months	Plays pat-a-cake	<input type="checkbox"/>
10	15 months	Scribbles	<input type="checkbox"/>
11	15 months	Stoops and recovers	<input type="checkbox"/>
12	15 months	Takes lids off containers	<input type="checkbox"/>
13	15 months	Walks alone well	<input checked="" type="checkbox"/>

Remove From MyList **<16.11>**

Or enter new item for this group:

Add **<16.10>**

Add to MyList **<16.9>**

**My Current Groups:**

- 15 months
- 6 Years

Figure 16.8

## 14.0 Anticipatory Guidance:

This page is used to record provider's notes of anticipatory guidance of children. The provider is provided with a text box to freely type his/her notes into the system and save it (<17.2>).

The screenshot displays the 'Anticipatory Guidance' form within the CyberMed EHR interface. The form is titled 'Anticipatory Guidance' and is part of the 'JOSEPH P. ADDABBO FAMILY HLTH CNTR' system. It includes fields for 'Acct#:', 'Name:', 'Sex:', 'DOB:', 'Age:', 'MRN:', and 'Bal\_Due:'. A 'Previous Guidances:' section shows a table with columns for 'Visit' and 'User', containing a record for '8/28/2012' by 'CPETERS'. A 'Context:' text area contains the following text: 'The following anticipatory guidance is discussed or provided (Group:2wks-1 month): 2wks-1 month: Ability to roll; Burns from hot liquids; Burping; Feeding; Hiccups; Infant sleeping position; and Testing Anticipatory Guidance.' Below the text area are 'SAVE' and 'RESET' buttons. The form is surrounded by a navigation menu on the left with options like 'Patient's Chart', 'CDSS', 'Make/Discharge', 'Counter Form', 'Order Entry', 'Prescribing', 'Medical Charting', 'Problem List', 'HPI', 'ROS', 'Physical Exam', 'Dev. Assessment', 'Anti. Guidance', 'Treatment Plan', and 'Care Transition'. The top of the form has a 'Welcome, CPETERS' login message and a 'Pharm:9, Fax:66, Pending:459' status bar.

Anticipatory Guidance

Acct#: Name: Sex: DOB: Age: MRN: Bal\_Due: \$0.00

Previous Guidances: Create New

Visit	User
8/28/2012	CPETERS

Select template: CPETERS Use SmartNotes Tool

Context:

The following anticipatory guidance is discussed or provided (Group:2wks-1 month):  
2wks-1 month: Ability to roll; Burns from hot liquids; Burping; Feeding; Hiccups; Infant sleeping position; and  
Testing Anticipatory Guidance.

SAVE RESET

Figure 17.1

## 14.1 Use SmartNotes Tool:


This is a tool generated to help the providers to enter the desired information with minimum typing. Click on the button “*Use Smart Notes Tool*” to go to the page (<17.3>). Select an age group from the drop down. Select various items from the available list (<17.4>). If any additional notes are to be added in any category please add it to the comments box available at the bottom of the page (<17.5>).

You can overwrite the existing notes or append/add to the existing notes by selecting the radio button at the end of the page and click on “*Generate Smart Notes*” (<17.6>). This will add your selections to the note’s text box in a format. The provider can add/make additional changes to the text if he wishes (<17.2>).

The screenshot shows the 'Anticipatory Guidance' tool interface. On the left is a sidebar with navigation links: Patient's Chart, CDSS, Intake/Discharge, Encounter Form, Lab Order Entry, E-Prescribing, Medical Charting, and Problem List. The main header displays 'JOSEPH P ADDABBO FAMILY HLTH CNTR' with navigation tabs: Home, Provider, Front Desk, Billing, Clerk, Reports, and Control Panel. The form fields include 'Acct#:', 'Name:', 'Sex:', and 'DOB:'. Below these are buttons for '< Back', 'Unselect All', and 'Select All', along with a 'Select group:' dropdown menu set to '2wks-1 month'. A list of checkboxes for various milestones is shown, with some already selected: 'Ability to roll', 'Breast vs. formula feeding', 'Burns from hot liquids', 'Burping', 'Falls', 'Feeding', 'Hiccups', 'Infant car seat', and 'Infant sleeping position'. A 'Comments:' text area contains the text 'Testing Anticipatory Guidance.'. At the bottom, there are radio buttons for 'Overwrite' and 'Append', and a green 'Generate Smart Notes' button. Arrows point from labels to specific UI elements: '<17.4>' points to the checkbox list, '<17.5>' points to the comments text area, and '<17.6>' points to the 'Append' radio button and the 'Generate Smart Notes' button.

Figure 17.4

## 14.2 Make Your Own Template:

In order to make your own Anticipatory Guidance template click on the symbol . Select the age group and select the available items from the list and click on “Add to My List” (<17.8>). If desired to add an item that is not available in the list, there is a text box saying “Or Enter New Item for This Group:” Type the new item and click on “Add” to add the item to the list (<17.9>).

This template can be composed at one time and will be available for the patient’s anticipatory guidance. Any changes/ add/ removal of item reflects there-on-wards. In order to remove an item from your list, select the item and click on “Remove from My list” (<17.10>).

On going back to anticipatory guidance, the provider would find the template for smart notes default to the user template. In order to view regular template please select regular in “Template”.

Figure 17.7

## 15.0 Treatment Plan:

This page is used to record provider's plan of treatment for the patient. The provider is provided with a text box to freely type his/her notes into the system and save it (<18.2>).

The screenshot displays the 'Treatment Plan' form within the CyberMed EHR system. The interface includes a top navigation bar with links like 'Home', 'Provider', 'Front Desk', 'Billing', 'Clerk', 'Reports', and 'Control Panel'. A left sidebar contains various menu items such as 'Patient's Chart', 'CDS', 'Intake/Discharge', 'Encounter Form', 'Lab Order Entry', 'E-Prescribing', 'Medical Charting', 'Problem List', 'HPI', 'ROS', 'Physical Exam', 'Dev. Assessment', 'Anti. Guidance', 'Treatment Plan', and 'Care Transition'. The main form area is titled 'Treatment Plan' and contains fields for 'Acct#:', 'Name:', 'Sex:', 'DOB:', 'Age:', 'MRN:', and 'Bal\_Due:'. Below these fields is a 'Tx Plan List' table with columns for 'Visit' and 'User'. A 'Context:' section contains a text box with the text 'Recommended the following treatment plan: CTScan: Abdomen; Elbow (L); Knee (R); Lumbar Spine; and Patient treatment plan testing.'. A 'Select Template:' dropdown menu is set to 'CPETERS', with a list of templates including 'CPETERS', 'REGULAR', 'DIABETES', and 'HYPERTENSION'. A 'Use SmartNotes Tool' button is visible. At the bottom of the form are 'SAVE' and 'RESET' buttons. Annotations include an arrow pointing to the text box labeled '<18.2>' and another arrow pointing to the 'Use SmartNotes Tool' button labeled '<18.3>'.

Figure 18.1

## 15.1 Use SmartNotes Tool:

The provider can select predefined templates for diagnosis like regular, hypertension, diabetes, and asthma from the “*Select Template*” dropdown (<18.3>).

For the regular template, SmartNotes Tool is a tool generated to help the providers to enter the desired information with minimum typing. Click on the button “*Use SmartNotes Tool*” to go to the page (<18.3>).

You can overwrite the existing notes or append/add to the existing notes by selecting the radio button at the end of the page and click on “*Generate Smart Notes*” (<18.5>). This will add your selections to the note’s text box in a format. The provider can add/make additional changes if he wishes.


The screenshot displays the JOSEPH P ADDABBO FAMILY HLTH CNTR interface. On the left is a navigation menu with options: Patient's Chart, CDSS, Intake/Discharge, Encounter Form, Lab Order Entry, E-Prescribing, and Medical Charting. The main content area is titled 'Treatment Plan' and includes fields for Acct#, Name, and Sex. Below these are buttons for '< Back' and 'Reset All Selections'. A section titled 'CTScan' contains checkboxes for Abdomen, Chest, Knee (L), Lumbar Spine, Cervical, Elbow (L), and Knee (R). Below the checkboxes is a text box with the text 'Patient treatment plan testing.' At the bottom of the form are radio buttons for 'Overwrite' and 'Append', and a green button labeled 'Generate Smart Notes'.

Figure 18.4

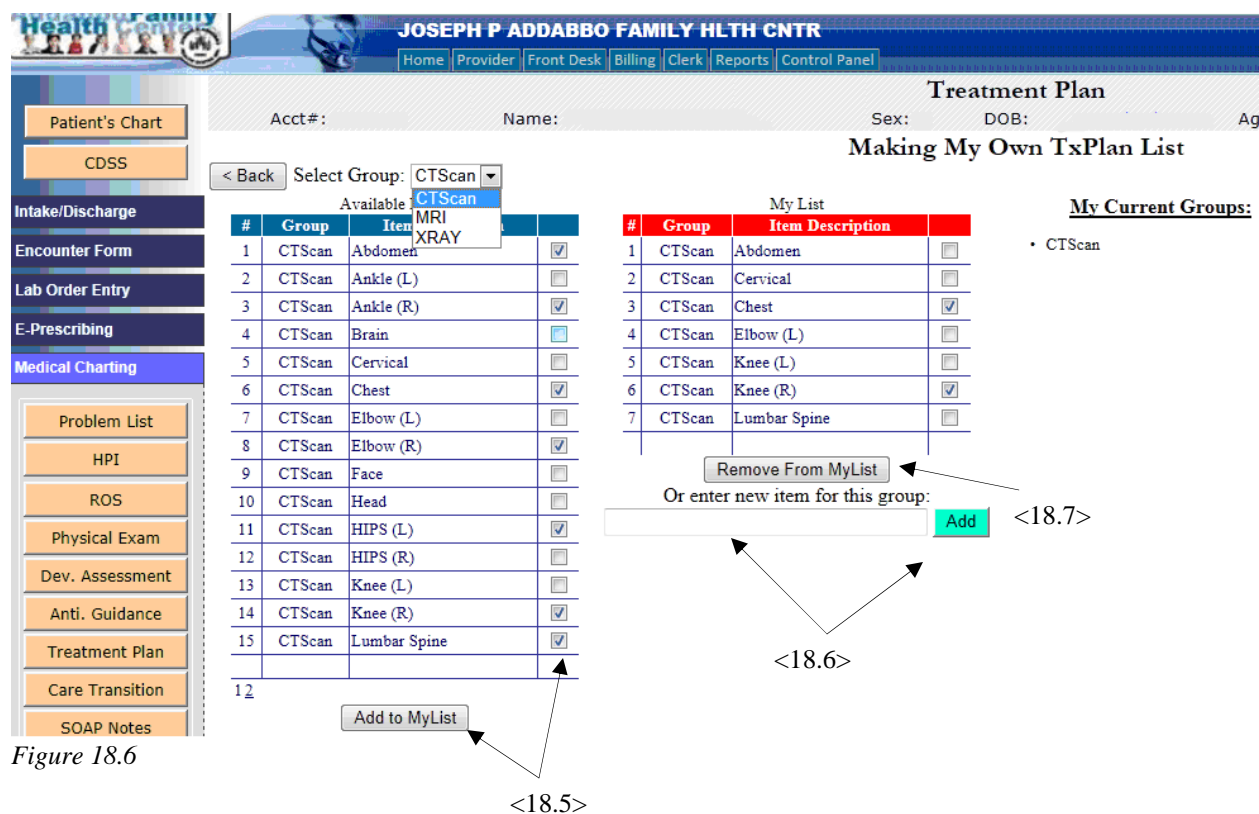
<18.5>



## 15.2 Make Your Own Template:

In order to make your own treatment plan template click on the symbol . Select the group of category and select the available items from the list and click on “Add to My List” (<18.5>). If desired to add an item that is not available in the list, there is a text box saying “Or Enter New Item for This Group”. Type the new item and click on “Add” to add the item to the list (<18.6>).

This template can be composed at one time and will be available for the patient’s treatment plan. Any changes/add/removal of item reflects there-on-wards. In order to remove an item from your list, select the item and click on “Remove from MyList” (<18.7>). On going back to treatment plan, the provider would find the template for smart notes default to the user template. In order to view regular template, please select “Regular” in “Template”.



**Treatment Plan**

Acct#: Name: Sex: DOB: Ag

**Making My Own TxPlan List**

< Back Select Group: CTScan

#	Group	Item	
1	CTScan	Abdomen	<input checked="" type="checkbox"/>
2	CTScan	Ankle (L)	<input type="checkbox"/>
3	CTScan	Ankle (R)	<input checked="" type="checkbox"/>
4	CTScan	Brain	<input type="checkbox"/>
5	CTScan	Cervical	<input type="checkbox"/>
6	CTScan	Chest	<input checked="" type="checkbox"/>
7	CTScan	Elbow (L)	<input type="checkbox"/>
8	CTScan	Elbow (R)	<input checked="" type="checkbox"/>
9	CTScan	Face	<input type="checkbox"/>
10	CTScan	Head	<input type="checkbox"/>
11	CTScan	HIPS (L)	<input checked="" type="checkbox"/>
12	CTScan	HIPS (R)	<input type="checkbox"/>
13	CTScan	Knee (L)	<input type="checkbox"/>
14	CTScan	Knee (R)	<input checked="" type="checkbox"/>
15	CTScan	Lumbar Spine	<input checked="" type="checkbox"/>

Available: CTScan, MRI, XRAY

#	Group	Item Description	
1	CTScan	Abdomen	<input type="checkbox"/>
2	CTScan	Cervical	<input type="checkbox"/>
3	CTScan	Chest	<input checked="" type="checkbox"/>
4	CTScan	Elbow (L)	<input type="checkbox"/>
5	CTScan	Knee (L)	<input type="checkbox"/>
6	CTScan	Knee (R)	<input checked="" type="checkbox"/>
7	CTScan	Lumbar Spine	<input type="checkbox"/>

**My Current Groups:**

- CTScan

Remove From MyList

Or enter new item for this group:

Add

<18.5>

<18.6>

<18.7>

Figure 18.6

## 16.0 Soap Notes:

SOAP notes are basically a summary of all the providers' assessment of the patient's visit. If the provider has completed various charting, encounter, ERx, labs, etc., the auto notes items are already highlighted on the right side of the page (<19.2>).

To add the SOAP notes, select the items of notes to be added on the right side of the page and click on "Add/Refresh" (<19.3>). This would update the text area with a pre-designed template of SOAP notes with your various notes from the different categories already embedded into each category. If the provider has not recorded any category, he can still add his notes by typing in that part of SOAP notes. Select the category on the right side and click on "Add/Refresh." This would allow a blank slot for the provider to type his/her notes.

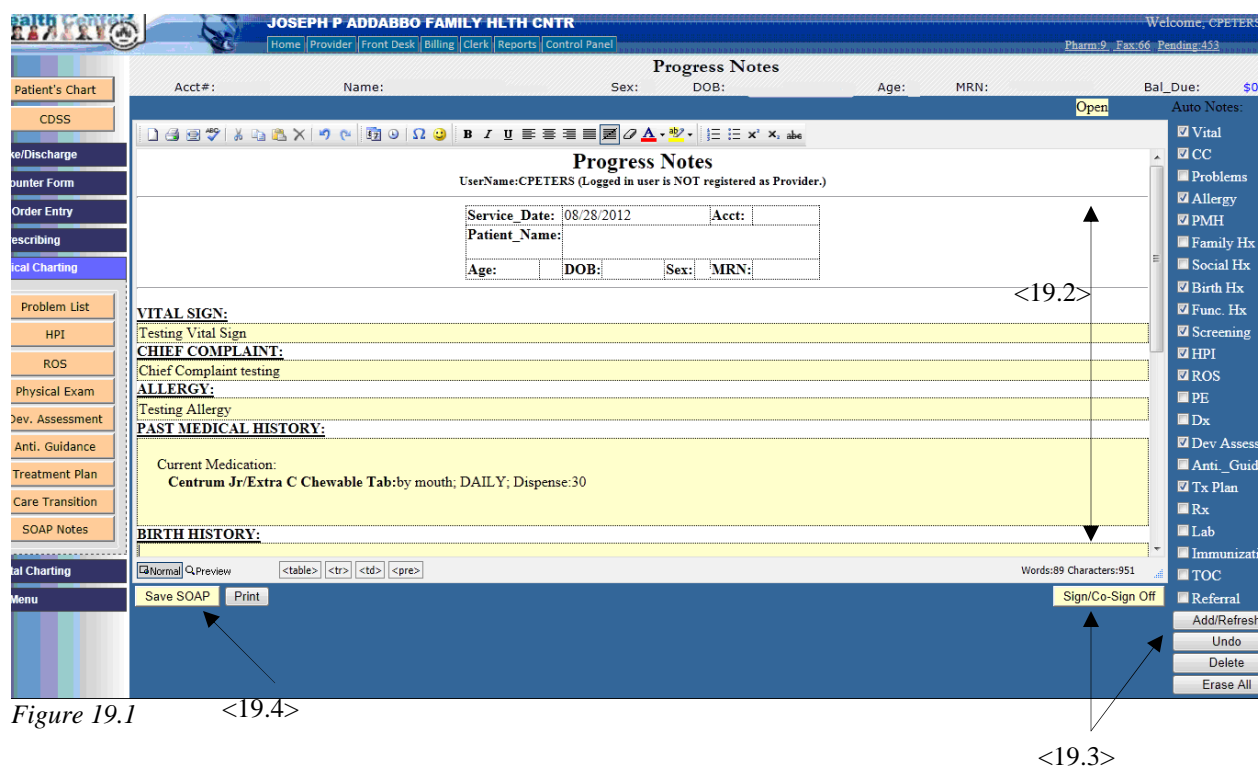


Figure 19.1

**“Please Note:** If a provider types in text SOAP notes and then for any reason clicks on “Add/Refresh”, the notes that were typed will be erased and the original template with the selected categories and text from those categories will appear. You can “Undo, Delete or Erase All” by clicking on the respective button on the right side of the page (<19.3>). Once the notes are reviewed and the respective changes have been made, click on “Save SOAP” to save the soap notes. (<19.4>)

**Please Note:** “Save SOAP” does not mean the provider has signed off. It just saves the provider’s notes. This can be modified afterwards. However, the button “Sign/Co-Sign off” is used only when the provider has finished all review and finalized to sign it off and lock from further changes.

**Please Note:** Once the notes are sign/co-sign off, additional changes cannot be added. This is the reason the system asks for the provider to enter their pin number.

**Fix Errors in Signed SOAP Notes:** If a provider for any reason wishes to record an important change to a SOAP note which is already signed off, he can record the change only by clicking again on “Sign/Co-Sign Off” and adding his text to additional notes.

**For Example:** The provider has entered the wrong diagnosis and signed off the SOAP notes. Later he realizes it and wants to correct it. He/she can do that by clicking on “Sign/Co-Sign Off” and adding the changes to “Additional Notes”. (<19.6>)

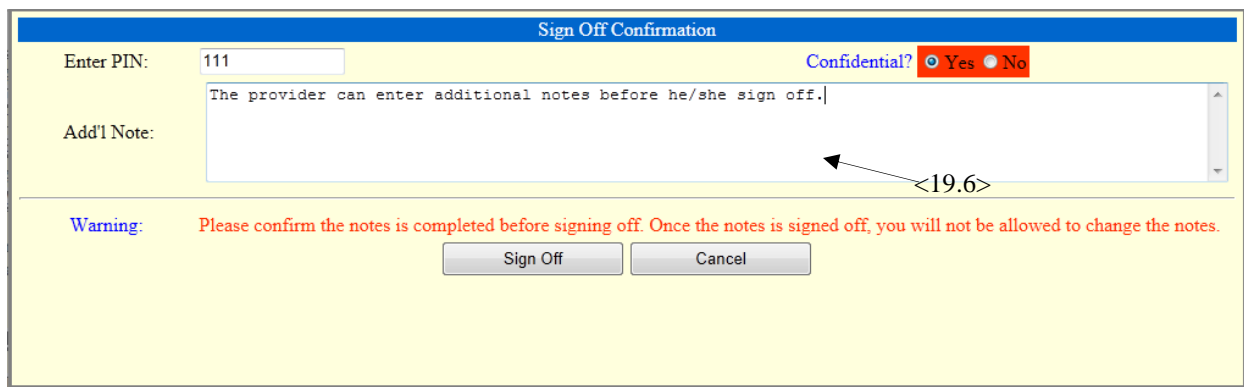


Figure 19.5

## 4.0 Provider Tab:

This section describes the various features available for the provider on the left navigation bar as shown below:



Figure 20.1

### 4.1 Office Mail:

This feature gives the provider the opportunity to send a mail/message to other Providers/Nurses/Medical Assistants within the organization or also to Providers or personnel outside the organization (provided the provider has the email address to whom he/she would like to send the message to) (<20.2>).

There are two tabs in the “Office Mail”. One is to the “MailBox” where the provider can view the received mails from other personnel. Other is the “Compose” tab where the provider can write a new message to be sent (<20.4>).

### 4.1.1 MailBox:

Click on “*Receive*” to view the updated messages in the inbox. You can sort the messages by Date, from, and Subject by clicking on the column’s name (Date/From/Subject) (<20.5>). To Read a message click on “*Read*”, the message appears below in the screen. We can reply to the sender by clicking on the “*Reply*” button or forward the message by clicking on the “*Forward*” button (<20.6>).

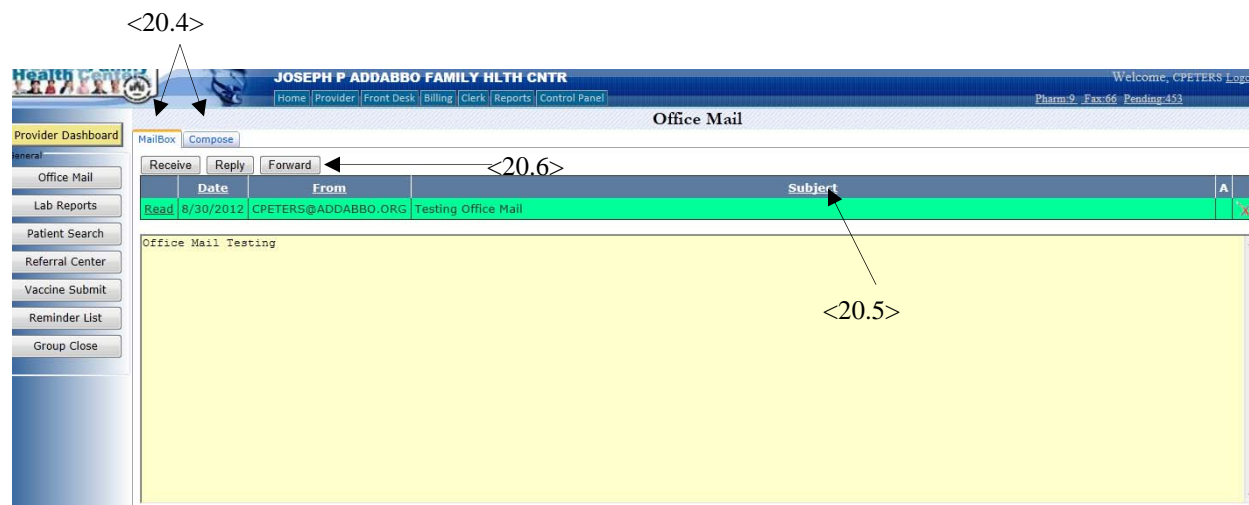


Figure 20.3

### 4.1.2 Compose:

To send a message internally to a user within the organization, please click on the "To" button and select the User ID from the list. To send a message to a personnel with an email ID that is outside of the organization, type in the text box next to the "To" button and fill in the remaining parts of the mail, click on "Send" (<20.8>). For example: username@yahoo.com. A message at the bottom of the page will read "Success". That means that your mail has been successfully sent.

The screenshot shows the 'Compose' email form in the CyberMed EHR system. The form is titled 'Office Mail' and is part of the 'JOSEPH P ADDABBO FAMILY HLTH CNTR' interface. The 'To' field contains 'username@yahoo.com', and the 'Subject' is 'Testing Office Mail'. The 'Attachment' field has a 'Browse...' button. The main text area contains the text 'Testing: Sending email to an external account outside of Addabbo.' A red 'Send' button is on the right. A yellow callout box labeled '<20.8>' points to the 'Send' button. A red callout box labeled '<20.7>' points to the 'Compose' button in the top navigation bar. The left sidebar shows various menu items like 'Provider Dashboard', 'Office Mail', 'Lab Reports', etc. The bottom of the form has fields for 'Option', 'Patient Account', and 'Submission Content Type'.

Figure 20.6



## 4.2 Lab Reports

This section allows the providers to check the pending lab/ lab result reports. Select the provider name and click on “Go” to view the pending lab reports (<21.2>). Select the patient and click on “View Detail” to open the lab result (<21.3>).

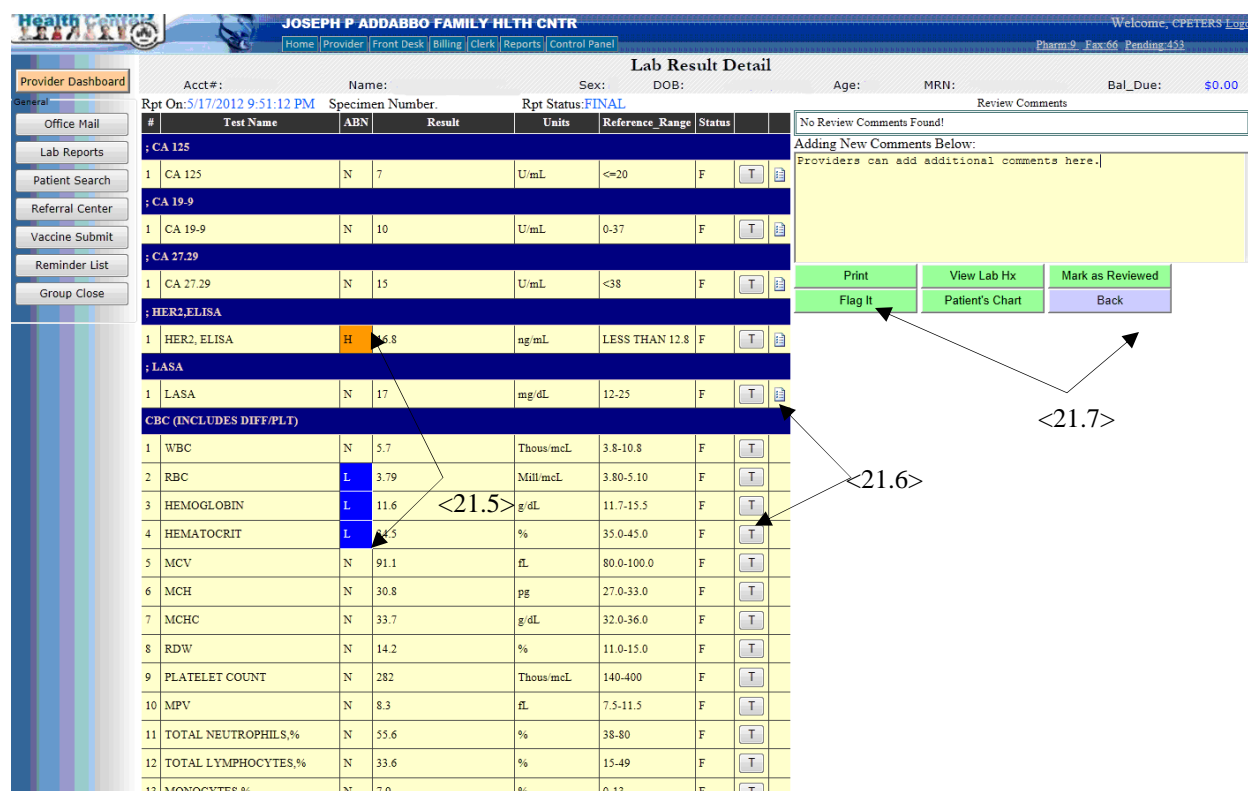
The screenshot displays the 'Lab Data Review' section of the CyberMed (EHR) system. The interface includes a navigation menu on the left with options like 'Office Mail', 'Lab Reports', 'Patient Search', 'Referral Center', 'Vaccine Submit', 'Reminder List', and 'Group Close'. The main area shows a list of providers under the 'Report' tab. A 'Go' button is located next to the provider list. Below the provider list is a table of lab reports with columns: 'Report', 'DOB', 'Request Date', 'Request By', 'Order Status', 'Review Status', and 'View Detail'. An arrow points from the 'Go' button to the '<21.2>' label. Another arrow points from a 'View Detail' button to the '<21.3>' label.

Report	DOB	Request Date	Request By	Order Status	Review Status	View Detail
AM_AKHAND	/1965	4/10/2012	AKHAND	CM	N	View Detail
AM_BARCIA	1945	5/17/2012	AKHAND	CM	N	View Detail
AM_BUNYAVANICH	1966	5/14/2012	AKHAND	CM	N	View Detail
AM_BURGOS	1/1970	5/17/2012	AKHAND	CM	N	View Detail
AM_CARMENATE	/1961	5/9/2012	AKHAND	CM	N	View Detail
AM_CHAKOTE	8/1943	5/11/2012	AKHAND	CM	N	View Detail
AM_CHAN	/1967	5/10/2012	AKHAND	CM	N	View Detail
AM_CHEN	/1977	5/8/2012	AKHAND	CM	N	View Detail
AM_DHILLON	/1967	5/10/2012	AKHAND	CM	N	View Detail
AM_FERDOUS	9/1955	5/8/2012	AKHAND	CM	N	View Detail
AM_GO						
AM_HILL						
AM_HOLALKERE						
AM_JACOB						
AM_KALEPU						
AM_KHAN						
AM_KIM						
AM_MADHURAPANTULA						
AM_MAYARD						
AM_PATEL						
AM_PATTUGALAN						
AM_PIERRO						
AM_RIGAUD						
AM_RODRIGUEZ						
AM_SAM						
AM_THOMPSON						
AM_VALEUS						
AM_VARGHESE						
CDT_CROSBY						
CDT_LAMB						

Figure 21.1

Each test result is color coded based on its abnormality in the case of high/low (<21.5>). You can also view the trend by clicking  with the similar previous tests if ordered. There is a  symbol which indicates an important message from Quest to the provider regarding the test (<21.6>).



















The provider is advised to put in the comments and when reviewed click on “*Mark as Reviewed*”. If the provider wishes to check on a pending item/ or recall the patient, click on “*Flag It*” to add this patient’s lab to the flagged list. Click on “*View Lab Hx*” to view the patient’s previous lab histories (<21.7>).



**Lab Result Detail**

Acct#: \_\_\_\_\_ Name: \_\_\_\_\_ Sex: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ MRN: \_\_\_\_\_ Bal\_Due: \$0.00

Rpt On: 5/17/2012 9:51:12 PM Specimen Number: \_\_\_\_\_ Rpt Status: FINAL

#	Test Name	ABN	Result	Units	Reference_Range	Status	
<b>: CA 125</b>							
1	CA 125	N	7	U/mL	<=20	F	
<b>: CA 19-9</b>							
1	CA 19-9	N	10	U/mL	0-37	F	
<b>: CA 27.29</b>							
1	CA 27.29	N	15	U/mL	<38	F	
<b>: HER2, ELISA</b>							
1	HER2, ELISA	H	6.8	ng/mL	LESS THAN 12.8	F	
<b>: LASA</b>							
1	LASA	N	17	mg/dL	12-25	F	
<b>CBC (INCLUDES DIFF/PLT)</b>							
1	WBC	N	5.7	Thous/mcL	3.8-10.8	F	
2	RBC	L	3.79	Mill/mcL	3.80-5.10	F	
3	HEMOGLOBIN	L	11.6	g/dL	11.7-15.5	F	
4	HEMATOCRIT	L	34.5	%	35.0-45.0	F	
5	MCV	N	91.1	fL	80.0-100.0	F	
6	MCH	N	30.8	pg	27.0-33.0	F	
7	MCHC	N	33.7	g/dL	32.0-36.0	F	
8	RDW	N	14.2	%	11.0-15.0	F	
9	PLATELET COUNT	N	282	Thous/mcL	140-400	F	
10	MPV	N	8.3	fL	7.5-11.5	F	
11	TOTAL NEUTROPHILS,%	N	55.6	%	38-80	F	
12	TOTAL LYMPHOCYTES,%	N	33.6	%	15-49	F	
13	MONOCYTES,%	N	7.9	%	0-13	F	

No Review Comments Found!

Adding New Comments Below:  
Providers can add additional comments here.

Print View Lab Hx Mark as Reviewed  
Flag It Patient's Chart Back

Figure 21.4



### 4.2.1 Lab Search

This section allows the provider to search for labs of a patient based on the patient's account number, or name. Enter the patient's information in the textbox and click on “*Find Patient*” (<21.9>). Select the patient from the list result generated. If the patient has labs with the organization, all his previous labs will appear on the right side of the page. Click on “*View*” to view the patient's lab (<21.10>).

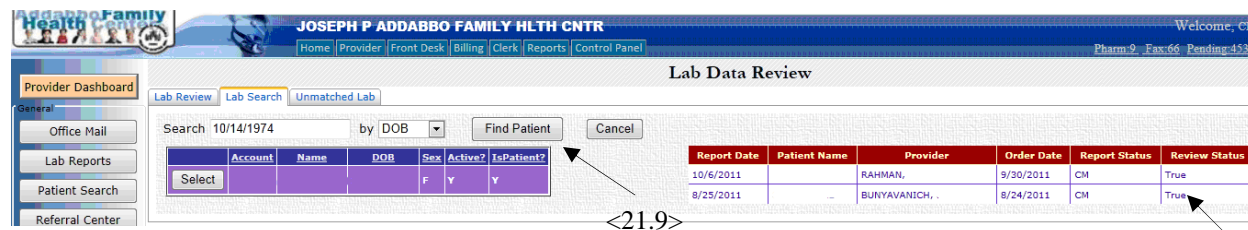


Figure 21.8

<21.10

### 4.2.2 Unmatched Lab

This section allows the provider to link an unmatched lab with the account number manually.

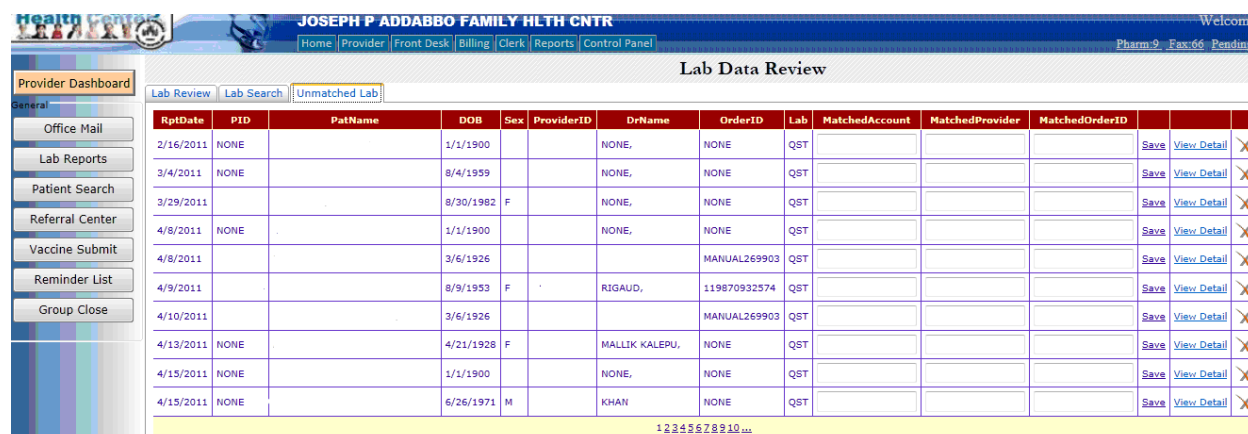


Figure 21.11

### 4.3 Patient Search

This feature allows the user to search for a patient based on their account number, name, date of birth or MRN. Enter the appropriate number/text in the search field and make a selection from the “*In Field*” drop down. Click on the “*Search*” button to search for the patient (<21.14>).

If multiple results appear in the list as shown below, select the right patient based on other information. Click on “*Demographics*” to view the patient’s demographics or “*Show Visits*” to view the patient’s past visits or “*Patient Chart*” to be redirected to the patient’s chart information (<21.13>).

**JOSEPH P ADDABBO FAMILY HLTH CNTR**

Home Provider Front Desk Billing Clerk Reports Control Panel

**Patient Search**

Search: 10/21/1998 In Field: DOB Search <21.14>

Total Return Rows: 3

	Account	Name	DOB	Sex	MRN	Active?	IsPatient?
Demographics Show Visits Patient Chart				M		Y	Y
Demographics Show Visits Patient Chart				M		Y	Y
Demographics Show Visits Patient Chart				M		Y	





Figure 21.12

<21.13>

#### 4.4 Referral Center:

This section is for the provider to view the incoming/outgoing and referrals waiting for the provider to review. Click on each tab to view the sections.

Select the provider's name from the drop down list. The page is then automatically refreshed. By default the page displays all open referrals. To view other status referrals select from the dropdown list of "Show Referral Status" and click on "Refresh" (<21.16>).

The list appears on "Refresh". Click on "Detail" to view the patient's referral. The referral can be printed by clicking on . You can also view the referral report by clicking on . In order to delete the referral, click on . The referral can be locked from any further changes by clicking on .

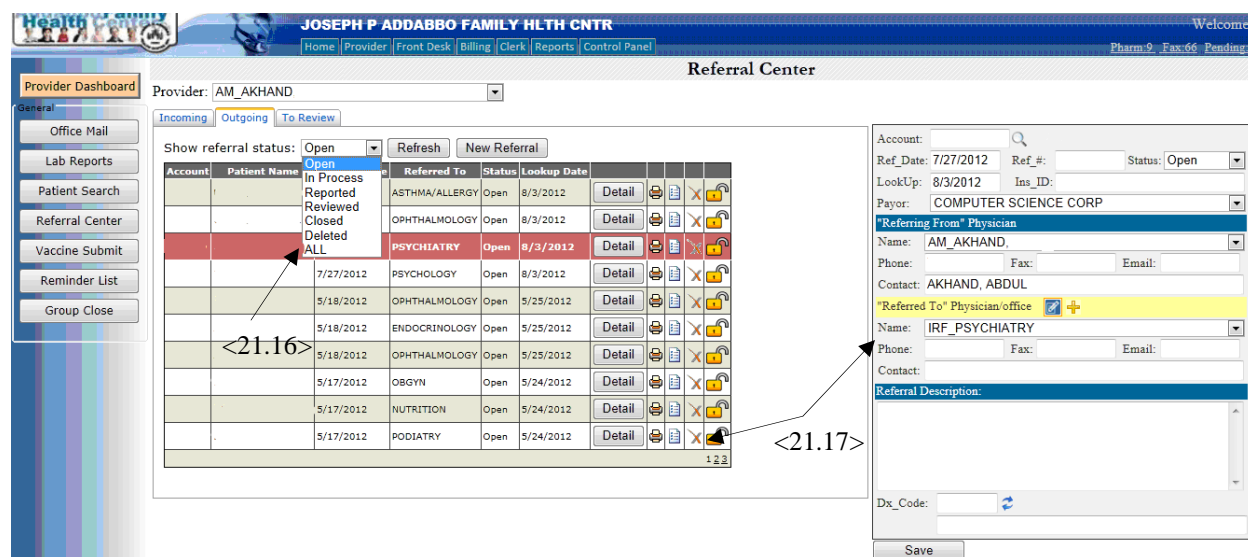


Figure 21.15

## 4.5 Provider Dashboard:

Please select the provider name from the dropdown list of “*Provider*”. This will automatically refresh the page with the provider’s information.

### 4.5.1 Chart

This section displays a chart view of the provider’s unsigned off notes, unclosed encounters and un-reviewed labs.

The blue bar of the chart displays the average number of the providers of the organization. The red bar displays the provider’s numbers.

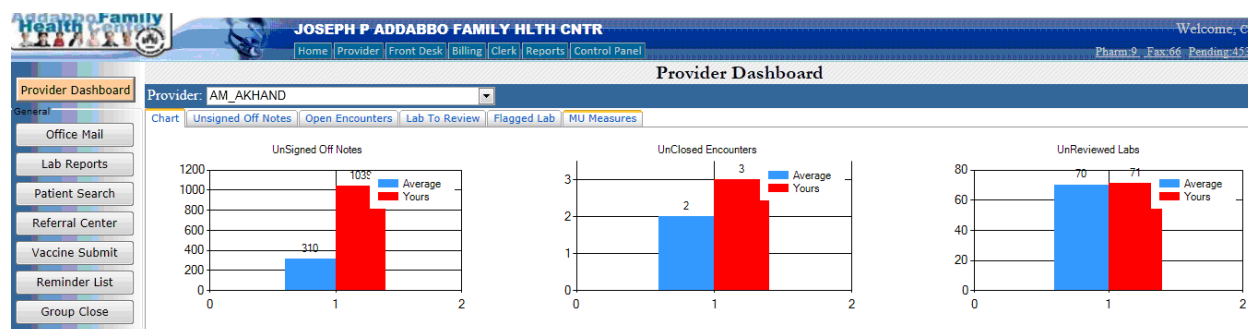


Figure 22.1

### 4.5.2 Unsigned off notes:

This section displays a list of all the notes to be signed off. The provider can easily open and review the notes and thus sign off notes by clicking on the “*Select*” link of each patient which will redirect to the patients chart and SOAP notes (<22.4>).

**JOSEPH P ADDABBO FAMILY HLTH CNTR**

Home Provider Front Desk Billing Clerk Reports Control Panel

**Provider Dashboard**

Provider: AM\_AKHAND

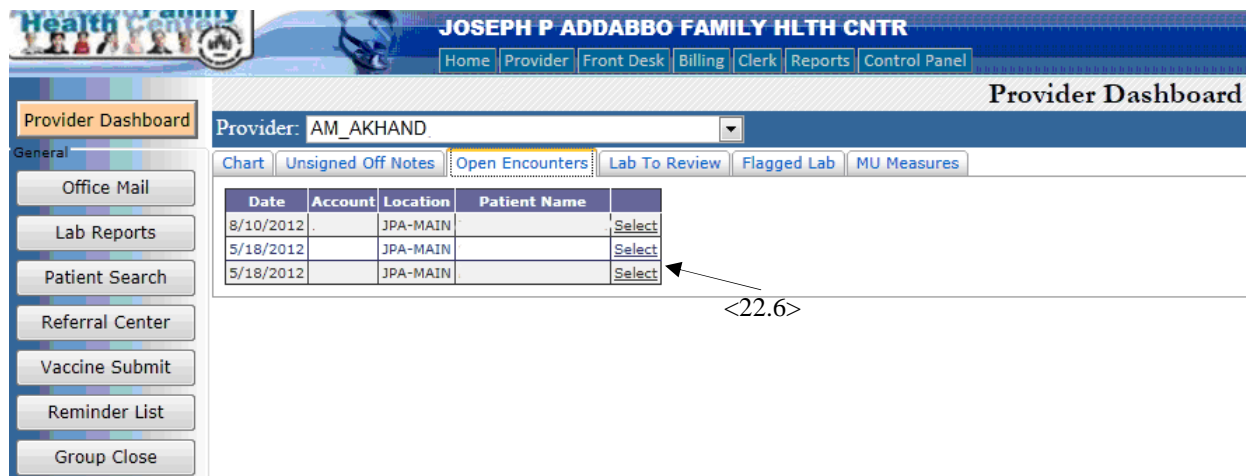
Chart Unsigned Off Notes Open Encounters Lab To Review Flagged Lab MU Measures

Date	Account	Location	Patient Name	Select
7/9/2012		JPA-MAIN		Select
6/12/2012		JPA-MAIN		Select
5/19/2012		JPA-JAM		Select
5/14/2012		JPA-CEN		Select
5/14/2012		JPA-CEN		Select
5/14/2012		JPA-CEN		Select
5/14/2012		JPA-MAIN		Select
5/14/2012		JPA-MAIN		Select
5/10/2012		JPA-MAIN		Select
5/9/2012		JPA-MAIN		Select
5/9/2012		JPA-MAIN		Select
5/8/2012		JPA-MAIN		Select
5/7/2012		JPA-CEN		Select
5/7/2012		JPA-CEN		Select
5/7/2012		JPA-CEN		Select
5/7/2012		JPA-CEN		Select
5/7/2012		JPA-CEN		Select
5/7/2012		JPA-MAIN		Select
5/4/2012		JPA-MAIN		Select
5/4/2012		JPA-MAIN		Select
5/4/2012		JPA-MAIN		Select
5/4/2012		JPA-MAIN		Select
5/2/2012		JPA-MAIN		Select
5/1/2012		JPA-MAIN		Select

Figure 22.2

### 4.5.3 Open Encounters:

This section displays a list of all the encounters that are not closed. The provider can easily review these encounters by clicking on the “*Select*” link of each patient which will redirect to the patients chart and encounter form (<22.6>).



**JOSEPH P ADDABBO FAMILY HLTH CNTR**

Home Provider Front Desk Billing Clerk Reports Control Panel

**Provider Dashboard**

Provider: AM\_AKHAND

Chart Unsigned Off Notes **Open Encounters** Lab To Review Flagged Lab MU Measures

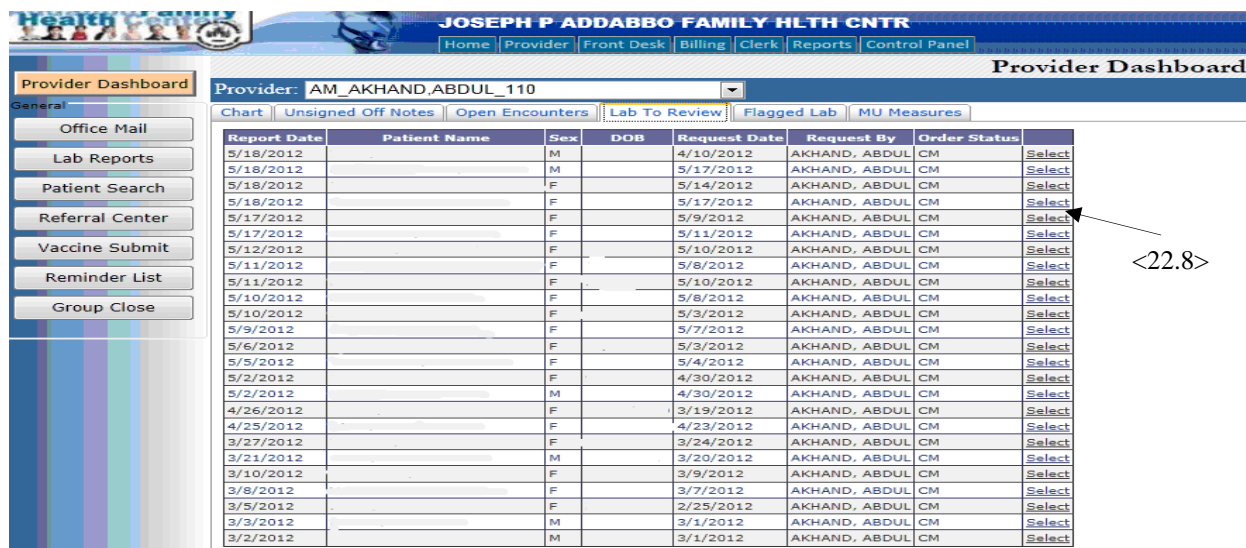
Date	Account	Location	Patient Name	
8/10/2012		JPA-MAIN		Select
5/18/2012		JPA-MAIN		Select
5/18/2012		JPA-MAIN		Select

<22.6>

Figure 22.5

### 4.5.4 Lab to Review:

This section displays a list of all the labs waiting to be reviewed. The provider can easily review these labs by clicking on the “*Select*” link of each patient which will redirect to the patients lab result report.



**JOSEPH P ADDABBO FAMILY HLTH CNTR**

Home Provider Front Desk Billing Clerk Reports Control Panel

**Provider Dashboard**

Provider: AM\_AKHAND.ABDUL\_110

Chart Unsigned Off Notes Open Encounters **Lab To Review** Flagged Lab MU Measures

Report Date	Patient Name	Sex	DOB	Request Date	Request By	Order Status	
5/18/2012		M		4/10/2012	AKHAND, ABDUL	CM	Select
5/18/2012		M		5/17/2012	AKHAND, ABDUL	CM	Select
5/18/2012		F		5/14/2012	AKHAND, ABDUL	CM	Select
5/18/2012		F		5/17/2012	AKHAND, ABDUL	CM	Select
5/17/2012		F		5/9/2012	AKHAND, ABDUL	CM	Select
5/17/2012		F		5/11/2012	AKHAND, ABDUL	CM	Select
5/12/2012		F		5/10/2012	AKHAND, ABDUL	CM	Select
5/11/2012		F		5/8/2012	AKHAND, ABDUL	CM	Select
5/11/2012		F		5/10/2012	AKHAND, ABDUL	CM	Select
5/10/2012		F		5/8/2012	AKHAND, ABDUL	CM	Select
5/10/2012		F		5/3/2012	AKHAND, ABDUL	CM	Select
5/9/2012		F		5/7/2012	AKHAND, ABDUL	CM	Select
5/6/2012		F		5/3/2012	AKHAND, ABDUL	CM	Select
5/5/2012		F		5/4/2012	AKHAND, ABDUL	CM	Select
5/2/2012		F		4/30/2012	AKHAND, ABDUL	CM	Select
5/2/2012		M		4/30/2012	AKHAND, ABDUL	CM	Select
4/26/2012		F		3/19/2012	AKHAND, ABDUL	CM	Select
4/25/2012		F		4/23/2012	AKHAND, ABDUL	CM	Select
3/27/2012		F		3/24/2012	AKHAND, ABDUL	CM	Select
3/21/2012		M		3/20/2012	AKHAND, ABDUL	CM	Select
3/10/2012		F		3/9/2012	AKHAND, ABDUL	CM	Select
3/8/2012		F		3/7/2012	AKHAND, ABDUL	CM	Select
3/5/2012		F		2/25/2012	AKHAND, ABDUL	CM	Select
3/3/2012		M		3/1/2012	AKHAND, ABDUL	CM	Select
3/2/2012		M		3/1/2012	AKHAND, ABDUL	CM	Select

<22.8>

Figure 22.7

## Flagged Lab:

This section displays a list of all the labs that are flagged by the provider to be reviewed for later again or waiting for some action like contact with the patient etc. The provider can easily review these labs by clicking on the “*Select*” link of each patient which will redirect to the patient’s lab result report and can thus view the comments to view about the lab (<22.10>).

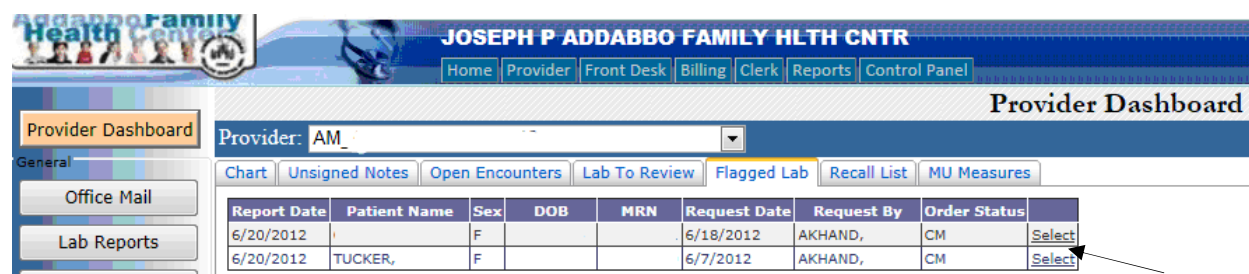


Figure 22.9

<22.10>

## 4.5.5 Recall List:

This section holds a list of all patients whose labs have been marked for recall.

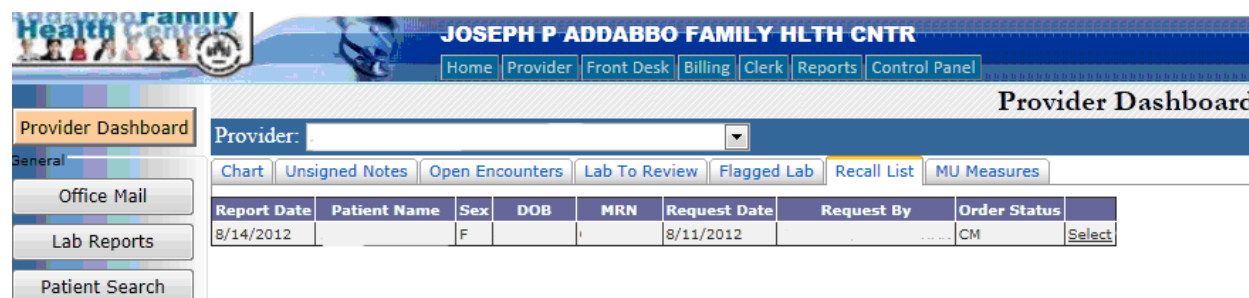


Figure 22.11